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IONAL HEALTH PROGRAM

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTIETH CONGRESS

FIRST SESSION

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 2

JUNE 25, 26, 27, JULY 2 AND 3, 1947

Printed for the use of the Committee on Labor and Public Welfare

UNITED STATES
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U.S. Congress. Senate. Committee on Labor and Public Welfare.

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NATIONAL HEALTH PROGRAM

WEDNESDAY, JUNE 25, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The committee met, pursuant to adjournment, at 9:30 a. m., in the committee room, Capitol Building, Senator H. Alexander Smith (chairman of the Subcommittee on Health) presiding.

Present: Senators Smith and Donnell.

Senator Smith. The committee will please be in order.

The first witness this morning is John Mannix, president, John Marshall Insurance Co., Chicago.

Is Mr. Mannix present?

(No response.)

Senator Smith. I understand Dr. Friedman is not to be here until later, so we will proceed with the next witness, Dr. Boas.

STATEMENT OF DR. ERNST P. BOAS, CHAIRMAN, THE PHYSICIANS FORUM, INC., NEW YORK, N. Y.

Senator Smith. Before you begin your testimony, Dr. Boas, will you give us a general background of your qualifications as a witness?

Dr. Boas. I am a practicing physician, specializing in diseases of the heart. I was graduated from the College of Physicians and Surgeons, Columbia University, in 1914. I served for 2 years in the First World War in the Medical Corps and was for 9 years medical director of Montefiore Hospital and professor of medicine at Columbia University as well as associate physician at Mount Sinai Hospital; and I am chairman of the Physicians Forum.

Senator Smith. You may proceed.

Dr. Boas. I appear in behalf of the Physicians Forum, a national organization of doctors, which includes among its members general practitioners, specialists, university professors, research workers, and public health physicians. The purpose of the forum is to contribute to the improvement and wider distribution of medical care, and to educate physicians and laymen in regard to the medical needs of the country. We are concerned with the quality of medical care, as well as with its more adequate distribution.

At a meeting of the executive committee of the Physicians Forum held on May 26, 1947, a motion was passed to disapprove of S. 545, and to support in principle S. 1320, and to authorize a representative to appear before this committee in the name of the forum. This action of the executive committee was approved at the annual membership meeting held at Atlantic City on June 12, 1947.

The proponents of both of the bills that are before this committee recognize the many serious inadequacies of health services in the United States, as well as the fact that large segments of the population do not receive proper medical care. It is unnecessary for me to elaborate on the facts in regard to the medical scene in the United States. They were documented and presented in detail by the spokesman for the United States Public Health Service at the hearings held in 1946 on S. 1606 before the Senate Committee on Education and Labor. They are well summarized in the report of the New York Academy of Medicine's Committee on Medicine and the Changing Order, published in 1947 by the Commonwealth Fund under the title: "Medicine in the Changing Order." I quote but two sentences from this report: "The poor and middle-income groups, being largely unable to pay for major medical expenditures, suffer financially or physically, or both, when serious or prolonged illness strikes. Today we are confronted with grave inequities in the medical services available to large segments of the rural population."

Evaluation of the two bills under discussion rests to some extent on certain basic assumptions. One may believe that the unfortunate inequalities and deficiencies in the distribution of medical care are not a major responsibility of the community, and that they can be corrected by charitable doles to those members of society whose insufficient incomes prevent them from obtaining adequate medical care. Or one may believe that every member of the community has the right of access to proper medical care, much as he has the right, and indeed the duty, to obtain an education. The Physicians Forum is of the opinion that every citizen, regardless of income, is entitled to complete medical care. Advances in the science and art of medicine have outstripped, by far, the methods for making these health services available to the average man. This gap must be bridged, both for the welfare of the Nation, and for the preservation of our democratic ideals.

Legislation designed to meet this end must insure the availability of complete medical care to all of the population; and it must provide that the quality of such care be of the highest. I propose to discuss the two bills from these general aspects.

The most important section of S. 545 provides for "general medical services for families and individuals with low income." The meaning of "low income" is not defined. The definition is apparently left to the States. Evidently it is the indigent and the medically indigent who are to be provided for. Therefore, in order to qualify for Government assistance under this bill self-respecting persons would be subjected to a means test. Determination as to who is eligible for total subsidy, who for partial, and who for none would demand a complex, burdensome, and expensive administrative machinery. The reintroduction of the charity concept into the field of public health and medical care reverses the trend that has been gaining momentum for several generations, namely, to regard health and medical measures as services needed by all citizens, and to free them from the yardstick of financial need. Eligibility for benefits would depend in part on State regulations, in part on the amount of money appropriated by

Congress. Senator Taft has estimated that the appropriation suggested in the bill would provide for from one-fifth to one-quarter of the population. Yet it is a well-established fact that at least 80 percent of the population cannot afford to buy complete medical care.

The bill provides grants-in-aid to the States, which must themselves appropriate an amount "at least equal to the Federal aid." The States may include in their contributions moneys already being spent by political subdivisions and by private institutions for medical care to the needy, so that the State's share of the expenditure need not represent any expansion of services. The low-income States will be entitled to proportionately larger sums of money than the high-income States, but they must contribute as large an amount of money as they receive, no matter how poor or prosperous they may be. It is well known that many of our States cannot afford such an expanded health program. Nothing in the bill requires a State to embark on a health program, or to request a grant-in-aid, so that it is quite possible that the poorest States, where the need is greatest, would fail to take much advantage of these Federal grants.

The total sum of Federal money appropriated in the bill is $200,000,000. Thus moneys available would be equivalent to about 8 percent of current expenditures for medical care, provided that the States matched every Federal dollar.

At the Federal level a new agency, the National Health Agency, is established. This agency would be under the direction of a physician and would be concerned only with health matters. It would include at least seven separate and independent bureaus, of which the United States Public Health Service would be one. All medical-care functions would be under the direction of a separate Office of Medical and Hospital Care Services, headed by a physician "who has had at least 5 years of active medical practice." This provision would bar from consideration such men as the present Surgeon General of the United States Public Health Service, and other men equally outstanding in the field of public health and medical care. The United States Public Health Service would be denied participation in the administration of the program of medical care, and the administration of preventive and curative medicine, which are but two aspects of sickness control, are becoming merged, largely as a result of the reduced incidence of the infectious diseases, and the ever-increasing prevalence of the so-called degenerative diseases of middle and later life. Preventive medicine begins with measures of personal hygiene and health examinations instituted by the general practitioner. Furthermore, separation of prevention and treatment of disease makes for administrative difficulties, adds unnecessarily to costs, and operates to protect the vested interests of private medicine.

It has become an accepted principle that while physicians must direct the technical aspects of a medical-care program, the public, through its Government and elected representatives, should establish the broad policies under which it should operate. Yet the bill establishes a National Medical Care Council which is to be dominated by professional representatives in a ratio of 5 to 3.

There are no provisions in the bill to insure that the expenditure of Federal funds will bring high-quality medical care to the recipients. The whole matter is left to the States; no basic standards or guiding principles are set forth. Once a State plan has been approved, all administration is left to the State. In each State there is to be a medical and hospital care advisory council; there is no insistence on consumer representation, but an explicit requirement that State medical and hospital associations be represented. No local advisory councils are set up; indeed, there are no specific provisions for local, city, or county administration.

The bill authorizes payments to be made—

> by the State, to any voluntary health, medical, or hospital insurance fund, or other fund not operated for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor.

Such granting of public funds directly to voluntary private agencies involves a vast transfer of authority and responsibility. Yet the bill sets no standards for the operation of these private agencies; sets no safeguards to control administrative costs, efficiency, or economy of operations, to protect the interest of the consumer, or to assure adequate services both quantitatively and qualitatively.

Senator SMITH. Doctor, may I interrupt you there a minute? You are implying that the State would not be competent to take care of those things. You are suggesting the State ought to be told what to do to run this thing.

Our theory in introducing S. 545 is that the thing should be decentralized to the States and the States challenged to work out the program.

You are implying that the States cannot be trusted even to be honest. I think that is going a little far.

Dr. BOAS. No, sir; I think we all know that the health services in the 48 States vary tremendously in efficiency and in quality, and it seems to me when such very large sums of Federal money are given as grants-in-aid to the States, there should be some very broad principles to insure that high, broad, general standards are maintained.

Senator SMITH. Then you would have the Federal Government determine those principles and lay down the rules and run the show, is that the idea? This is fundamental to the whole thing. The bill which you are supporting, S. 1320, would put a tax on everybody and raise somewhere between four and five billion dollars, which has appeared in our testimony already. That is an enormous sum of money.

The amount that S. 545 initially recommends is $200,000,000 a year to be handed over to the States on a matching basis and grants-in-aid on a scale in proportion to the wealth, and so forth, of the States. We think that proposal is just, and that is to be handled by the States in experimenting, if you will, for the best way to deal with this problem. We would have 48 States functioning, whereas under your proposal the tax would raise a tremendous sum of money and the Government would run the show from Washington, which we think is impossible from a practical standpoint, an administrative standpoint. I would like to see just what you are advocating.

Dr. BOAS. I agree with you it would be impractical and impossible and inadvisable for the Federal Government to try to run a detailed system of medical care from Washington. But I do think it would be wise for it to set certain broad standards: for instance, to state that by medical care is meant general practitioner care, specialist care, surgeon's business, laboratories, and the like.

In other words, that the broadest framework of the services to be rendered should be set down. Similarly——

Senator SMITH. That would be subject, then, of course, to the interpretation in case of conflict by the courts as to whether State aid is complying with these requirements to qualify for the grants. That means you get right into the courts to decide whether a State is doing the job it is to do. You have a definite requirement for what any State is to do, the State of New Jersey, my State—I do not know what your State is—the State of Pennsylvania, or the State of Nevada, the Federal Government will be saying to those States, "You have or have not complied with this intricate set of rules and standards." That is what troubles me with your proposal.

Dr. BOAS. Has it worked out that way in these—I forget the exact title—these Federal grants to the wives of veterans to pay for childbirth and the caring for infants? That has come through Federal funds. It has been administered by the States, but the Federal Government has set up rather strict principles of quality of care.

Senator SMITH. We are still observing that. But you are asking for over-all control; you are saying that one deficiency of S. 545 is that it does not give complete medical care. You use "complete medical care" in the early part of your statement.

Dr. BOAS. That is correct, sir.

Senator SMITH. And if you are contemplating that we can set up a system that would insure complete medical care to a man who pays a tax, that is the problem we have in this committee right straight through these hearings.

How do you go about it? How can you go about a scheme of raising taxes for a service you will not be able to fill? The only way to do is "pass the buck," to use a slang expression, to the States to work out their health program, and we are going to help you to do it, but the States must assume this burden and the Federal Government cannot dictate the terms. That is the difference between the two approaches.

I am speaking forcefully, not in disrespect to you but because I feel so strongly on the decentralization principle, and I think you do, fundamentally; but I think you are asking an impossible task when you say we must have this rule, and this rule, and this rule, in order to qualify for grants which would take you right into the courts every time.

The State would say, "We have qualified"; and the Federal department might say, "No; you have not"; and you would have to go to the courts to determine whether they had qualified or not. As soon as we get into that situation we are getting into a struggle between Federal and State control of the things that occur every day, in everyday life, which is a very serious step to take.

Dr. BOAS. It is my interpretation, sir, that the provisions of decentralization in S. 1320 try to meet that problem.

Senator SMITH. They try to but you are asking for conditions I do not think it would be possible to meet.

Dr. BOAS. I am suggesting that some analagous provisions, at least, be made.

Senator SMITH. I just want to get your position. Go ahead with your testimony. This is very important, to have your point of view on it; we are very glad to have it for it brings out what the real issue is in all these hearings.

Dr. Boas. There is no provision for preventive or laboratory services, no definition of hospital, surgical, or medical services, so that any of these may be greatly restricted in scope. There are no prescribed standards for the participating physicians or other medical personnel, no definition of the role of specialists, no standards for hospitals. In fact there is a clause that states that "nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of the health services with respect to which any funds have been or may be expended under this title." The inevitable result will be that medical services, for the most part, will be disorganized and inferior. There are no significant provisions, direct or indirect, to encourage the maintenance of a high quality of care.

A medical-care program must have assured appropriations year in and year out. There is no certainty that any of the funds authorized in S. 545 would ever be appropriated in fact. The bill merely indicates that Congress may appropriate these sums if it so desires. Thus the sums available for the medical-care program would depend from year to year on the climate of opinion in Congress. If there were an economy drive vital medical services might be jeopardized. This illustrates an important difference between S. 545 and an effective national health program. Such a program can be assured only through the device of social insurance in which taxes collected on a broad base are earmarked for health purposes.

Our objections to S. 545 may be briefly summarized. It is not a national health program, and it sets patterns of legislation that go counter to principles developed by progressive medical and public-health leaders during the past 20 years. It establishes the means test as a prerequisite for giving medical care, thus reverting to the outmoded concept of medical care as a charity to the needy. It sets no standards for such limited medical care as may be supplied under the bill, so that the poor, as today, will probably receive a kind of medical care inferior to that available to those who can afford to buy it. It turns over large Federal and State funds to private agencies with little or no control as to how they will be spent. It creates an artificial and costly barrier between methods of disease prevention and medical care. It is for these reasons that we disapprove of S. 545.

I will now address myself to S. 1320.

Senator Smith. Doctor, as I recall, you testified last year. We had 31 days of hearings on S. 1606. What we are profoundly interested to know now is the difference between S. 1606 and S. 1320 and not further affirmative argument in support of S. 1606, because we have thousands of pages of testimony on that which are all incorporated as part of this testimony. In other words, I do not want to duplicate our records if we can help it.

Dr. Boas. I will try to pick out the salient points.

Senator Smith. I would appreciate that very much because I would like to get your judgment on whether S. 1320 differs from S. 1606 of last year; if you have a point on that, that would be very helpful to us.

Dr. Boas. First of all, S. 1320 is based on the social-security principle and covers most of the population, and we approve of this wide coverage irrespective of income, for the need of Government arises from the fact that the vast majority of people cannot afford to pay individually for adequate medical care.

We believe in the social-security principle of payment because of this assurance that you will have money available year in and year out for the payment of medical services, because each worker will be making his own payment toward the cost of his own medical care and because these payments will be apportioned to his ability to pay.

Then we believe that because of the uneven distribution of the wealth in the United States, both as between individuals and large geographical areas, including large States, the Federal Government must assume responsibility for collecting the necessary funds and setting broad standards under which they should be spent.

Another reason for the Federal action is the increasing mobility of our population, through which the worker might lose his benefits when he moved from one State to another unless the health plan were national in scope.

In the following pages of my statement I discuss the administration of the bill. I do not know whether you want me to go into that. It differs considerably from S. 1606 of last year.

Senator SMITH. Could you give us the main differences?

We will have your statement incorporated in the record, but if also you give us in your testimony the main differences, the administrative features, between S. 1320 and S. 1606, we shall be pleased to have this information.

Dr. BOAS. S. 1320 spells out decentralization of administration in great detail. It is the intent of the bill that health benefits be administered wherever possible by the several States and each State is given great latitude in the details of administrative plan. The national agency is enjoined from exercising any authority with respect to the selection or compensation of any individual employed by the State in the administration of the act.

Furthermore, the personnel for health-service benefits are further decentralized by setting up local administrative units; these are to be set up by State authority and these local administrative units will make it possible to adapt the techniques to the local needs of the community and will assure maximum local autonomy because there is also provision at all levels for advisory boards.

I do not know whether you wish me to discuss some details of administration that I have in here.

Senator SMITH. It will all be incorporated. It is just if you feel it is important in pointing out the differences between S. 1606 and S. 1320. I think we covered S. 1606 in the testimony very thoroughly last year.

Dr. BOAS. High quality and complete medical care is made possible because the bill provides for all needed preventive, diagnostic, and curative services by a family physician of the patient's choice; services of specialists when required, hospital care, laboratory and X-ray services, unusually expensive medicines, special appliances, and eyeglasses. Dental, home nursing, and auxiliary services are provided to the extent that funds and personnel will allow. In the establishment of minimum standards for certain professional personnel, the aid of professional advisory boards is enlisted. Special funds are set aside for medical research and the training of physicians, dentists, and other professional personnel. Special provisions are made to help solve the problem of rural areas, particularly those in which critical shortages of professional personnel and facilities hamper the development of adequate health services.

Payments to physicians are to be adequate to give them assistance to pursuing postgraduate study, and to allow for adequate vacations. Unlimited opportunity for further development of group practice is given by the police of utilizing organizations qualified to render services. This is fundamental, for group practice is, without doubt, the practice of the future.

Senator SMITH. You said in the early part of your testimony that S. 1320's plan, as you read it, would cover about 90 percent of the population.

Dr. BOAS. Roughly.

Senator SMITH. About 90 percent?

Dr. BOAS. Yes, sir.

Senator SMITH. Then your whole theory is to tax all the people and then have them get free medical service in accordance with their needs, complete coverage by Federal- and State-directed medical service.

Dr. BOAS. Yes; excepting that I personally would not be inclined to call it free medical service because after all the people are paying for it.

Senator SMITH. It is given to them because of a tax—they will not pay what it cost—the individual of low income would pay a percentage as a tax on his pay roll and he would get the same as the man who paid the highest percentage of what his income might be.

Dr. BOAS. That is right.

Senator SMITH. An equalization process. It is a thought-out form of a social program for health.

Dr. BOAS. That is correct, sir.

Senator SMITH. People do not like the expression, "socialized medicine." I will not use that, but it is some form to take care of the health of all of our people; it contemplates the dropping out of the private practitioner in the old sense, and fee for service would disappear—entirely on a State payment basis for the entire medical profession.

If only 10 percent of the population are left in the old system and 90 percent get the benefit of this program, it seems to me you are contemplating that all doctors hereafter, both newcomers and those still in the profession, will go on a State or Federal pay roll.

Dr. BOAS. I do not think that is an absolutely accurate statement because while it is true that the payments could or would come out of the insurance fund, the amount that the doctor gets would still depend upon, within certain limits, his individual initiative and possible number of patients that he had and there would be no change in the methods of his practice. The only change would be in the method of his payment.

Senator SMITH. His payment would come through the tax fund that would be raised by this program, by this compulsory health-insurance program.

Have you any thought on this little side issue? There are a number of people that do not believe in this medical approach to health but believe in faith healings and that sort of thing. Are they taxed just the same whether they use the service or not, or do you exempt them, or what do you do?

Dr. Boas. As I understand it, they would be taxed just the same and there I think you could make an analogy between people who pay school taxes and send their children to private schools. That is their privilege if they wish it. You tax everybody and they choose some other method if they want to. They would have to pay but not to accept the service.

Senator Smith. I am interested to get that because I think we should have a clear understanding of what the different approaches are.

We probably all realize their importance and the importance of trying to get them clearly before us.

This you can appreciate.

Dr. Boas. This bill, like S. 545, has provision for existing voluntary nonprofit insurance agencies.

Senator Smith. Then you would wipe out the Blue Cross and the Blue Shield and those different group-insurance plans that are now in existence?

Dr. Boas. The bill as it stands does not wipe them out but takes advantage of them. I personally think that adds unnecessary complication to the administration because after all, most of these voluntary insurance plans are medical expense indemnity plans in which the voluntary insurance agency has to have salesmen to sell the insurance.

Now, since everybody would be automatically insured, that sales angle would seem quite unnecessary. They would then just act as intermediaries between the insurance fund and the recipients of medical care and the doctors.

Now, of course that used to be done in England and other European countries, and in Great Britain now, in their new law, they have been able to and have abolished these friendly societies as intermediaries because they found it did not work to the best advantage to have them; so it would seem to me it is inadvisable to set up that scheme here.

Senator Smith. I think with your plan, Doctor, those would just disappear.

Dr. Boas. On the other hand, purely service organizations such as the Ross-Loos Clinic in California or the Kaiser insurance plan, or the Endicott-Johnson plan where there is a group, an organized group of doctors, with a hospital giving service, service to people who pay insurance premiums, such a group would very properly be recognized by the insurance fund and the insurance fund could pay that organized group for doing the work it does now on a per capita basis.

So it would seem to me that the service groups should be maintained and recognized by the plan but that the other groups would be superfluous.

The bill retains the fee-for-service method of payment and we pointed out last year this system favors abuse and multiplies administrative difficulties.

It is our belief that if this bill were to go into effect, it would be much wiser to use to a large extent the capitation plan of payment of doctors.

Senator Donnell. I did not understand what you said, Doctor.

Dr. Boas. I mentioned the capitation plan.

Senator DONNELL. You are favoring the capitation plan or are opposed to it?

Dr. BOAS. We favor the capitation plan. We think the fee-for-service plan would not work well because it is subject to too much abuse and too much paper work.

Senator DONNELL. Did you say S. 1320? Did you say it maintains the fee-for-service plan?

Dr. BOAS. As one of the alternatives.

Senator DONNELL. And you do not favor the fee-for-service plan.

Dr. BOAS. That is correct, sir.

We endorse S. 1320, with the exception of the few items discussed above, because it establishes a true national health program, both for the prevention and treatment of disease. We support coverage of the vast majority of the people of the United States, and we approve of the social-security principle. The bill, while insuring that the medical care given shall be of high quality, gives great autonomy to individual localities to develop detailed professional arrangements best suited to their needs. Far from undermining personal relationships, S. 1320 breaks down the financial barrier between doctor and patient; it places the resources of modern medicine at the disposal of nearly all the people of this country. It permits the physician to develop his medical abilities to the greatest possible degree, and to place them at the service of his patients irrespective of their financial circumstances.

Senator SMITH. Thank you very much; I appreciate your testimony. I am going to ask Senator Donnell if he has questions.

Senator DONNELL. Doctor, at the outset of your testimony you said your appeared in behalf of the Physicians Forum, which you characterize as a national organization of doctors.

Dr. BOAS. That is correct.

Senator DONNELL. Would you tell us, please, how many members the Physicians Forum has?

Dr. BOAS. Approximately 1,000.

Senator DONNELL. So it has not grown since your testimony of less than a year ago?

Dr. BOAS. That is right.

Senator DONNELL. In how many States in the Union does your Physicians Forum have members?

Dr. BOAS. I cannot tell you that precisely but I should say between 25 and 30.

Senator DONNELL. And were all those members, principally, in what part of the country?

Dr. BOAS. Well, most of them are in the East, and I should say close to half of them are in New York State. We have chapters in Washington, D. C., in Chicago, and in San Francisco.

Senator DONNELL. Now, Doctor, last year in connection with your membership this colloquy occurred. The question was:

> Senator DONNELL. Do you know the number of members approximately that the forum has, we will say in the central West, in Missouri, and Kansas, and Nebraska and States of that type?
>
> Dr. BOAS. I do not think that we have very many. I think we just have a scattering in these particular States. We have a fair number in Illinois.
>
> Senator DONNELL. Your members are largely in States having the largest cities; is that right?
>
> Dr. BOAS. I suppose that is correct; yes, sir.

Senator DONNELL. I believe you said about 600 of them are in New York State?

Dr. BOAS. Yes, sir.

Senator DONNELL. That would leave, as Senator Ellender pointed out, about 300 scattered over the rest of the country?

Dr. BOAS. Yes, sir.

Now, Dr. Boas, is that testimony applicable at this time?

Dr. BOAS. Approximately correct; yes, sir.

Senator DONNELL. How long has the Physicians Forum been in existence?

Dr. BOAS. I believe for 7 years, but I may be in error.

Senator DONNELL. Came into existence in 1939, did it not?

Dr. BOAS. It came into existence as a local New York group in 1939, I believe.

Senator DONNELL. And then it was later made a national organization?

Dr. BOAS. Yes, sir.

Senator DONNELL. Now, I want to get, with some degree of care, the distribution of its membership into this record. You say you have approximately 1,000 members?

Dr. BOAS. Yes.

Senator DONNELL. Of whom approximately 600 are in New York State.

Dr. BOAS. Yes.

Senator DONNELL. How many of them are in Pennsylvania, if you know?

Dr. BOAS. It would have to be a pure guess because I do not know accurately.

Senator DONNELL. How many east of the Mississippi River?

Dr. BOAS. I should imagine, and again I cannot give you the absolutely accurate figure, that all but 100 are east of the Mississippi.

Senator DONNELL. Your best recollection is that all but 100 are east of the Mississippi River. In other words, approximately 100—I am not holding you down to the exact number—but approximately 100 are west of the Mississippi River?

Dr. BOAS. That would be a rough estimate; yes, sir.

Senator DONNELL. That is as close as you are able to give?

Dr. BOAS. Yes, sir.

Senator DONNELL. And you are head of the Physicians Forum, are you not?

Dr. BOAS. I am.

Senator DONNELL. And you have been head of that organization for several years; is that right?

Dr. BOAS. Yes.

Senator DONNELL. And now, Doctor, do you know how many States west of the Mississippi River that you have membership in?

Dr. BOAS. I really do not know exactly. Offhand, I happen to think of some members in California, Oregon, Oklahoma, and Colorado. We undoubtedly have others scattered around but I do not happen to recall them.

Senator DONNELL. Now, as a matter of fact, fully two-thirds of your membership are in a radius of not to exceed 250 miles from the Atlantic Ocean; that is correct, is it not?

Dr. BOAS. Probably; yes.

Senator DONNELL. That is your best judgment?

Dr. BOAS. Yes.

Senator DONNELL. Now, Doctor, there are in this country approximately how many practicing physicians?

Dr. BOAS. Well, I think there are about 180,000 physicians. I think the number of practicing physicians is in the neighborhood of 120,000.

Senator DONNELL. The American Medical Association has approximately how many members, if you know?

Dr. BOAS. I do not know for certain, but I think approximately 120,000.

Senator DONNELL. Approximately 120,000. Now, of your membership I notice you say that there are included not only general practitioners but specialists, professors, public health, research workers.

Of your entire membership of 1,000 or approximately that, how many are fully physicians?

Dr. BOAS. Practicing physicians, you mean?

Senator DONNELL. Any kind of physician, practicing or nonpracticing.

Dr. BOAS. All of them are physicians.

Senator DONNELL. They are all physicians, and of the 180,000 physicians in this country, your organization contains approximately one one-hundred-eightieth; that is correct, is it not?

Dr. BOAS. Yes.

Senator DONNELL. Now, Doctor, you are connected with quite a number of organizations that have been very active in connection with the Wagner-Murray-Dingell proposed legislation, are you not?

Dr. BOAS. I am connected with a number of them.

Senator DONNELL. For instance, you are connected, are you not, with the Committee on Research and Medical Economics?

Dr. BOAS. No, sir.

Senator DONNELL. Well, were you not on the editorial board of that organization, together with John P. Peters, last year?

Dr. BOAS. I was on the editorial board of Medical Care which was subsidized by that organization.

Senator DONNELL. All right. You were on that editorial board subsidized by the Committee on Research and Medical Economics, Michael M. Davis is the chairman of that committee, is he not?

Dr. BOAS. Yes.

Senator DONNELL. And he was last year?

Dr. BOAS. He was.

Senator DONNELL. And he was instrumental in getting you on that editorial board, was he not?

Dr. BOAS. He invited me to serve on it.

Senator DONNELL. You are also connected with an organization known as the Committee for the Nation's Health, are you not?

Dr. BOAS. I am.

Senator DONNELL. By the way, how large an organization is that committee, the Committee on Research and Medical Economics, do you know?

Dr. BOAS. It is a very small group. I do not know exactly. I think they have a board of directors of approximately 10 and that is all; and they just administer funds and set their policies, I believe.

I do not know much about the details of that organization.

Senator DONNELL. Do you know approximately how many members there are including the board of directors of the Committee on Research and Medical Economics?

Dr. BOAS. Well, I think that is all there is, just the board.

Senator DONNELL. Just 10?

Dr. BOAS. Something like that.

Senator DONNELL. That committee, however, is given a good deal of publicity, is it not, in connection with the Wagner-Murray-Dingell bill?

Dr. BOAS. So far as I know, it has not because that is——

Senator DONNELL. Well, your editorial work, for instance. Let me show you a pamphlet entitled, "Principles of a Nation-Wide Health Program. Copies of this report may be obtained from the committee, the same Committee on Research and Medical Economics, 1790 Broadway, New York 19, N. Y." That pamphlet is put out by the Committee on Research and Medical Economics, is it not?

Dr. BOAS. At least it was published by them.

Senator DONNELL. And it contains what is known as a report of the Health Program Conference; that is right, is it not?

Dr. BOAS. That is right.

Senator DONNELL. And you are a member of that Health Program Conference, are you not?

Dr. BOAS. I was. That was a temporary conference which met to set up these standards.

Senator DONNELL. Well, now, do you know whether it is a fact that when Senator Wagner introduced the national health bill in 1945 that he quoted considerably from the so-called principles of Nation-wide health program which was issued by this Committee on Research and Medical Economics?

Dr. BOAS. I do not know whether that is a fact or not.

Senator DONNELL. You do not know whether that is true or not.

As a matter of fact, Doctor, do you not know that his speech was reported in the Congressional Record, volume 91, page 10, and following, November 19, 1945; that it quotes extensively from this particular booklet; do you not know that?

Dr. BOAS. I do not know it.

Senator DONNELL. Did you not have any conference with Senators Wagner or Murray in regard to preparation of this booklet?

Dr. BOAS. None whatsoever.

Senator DONNELL. But you did have conference, did you not, with Mr. Michael M. Davis, in regard to the preparation of this document? Is that right?

Dr. BOAS. That document is the result of a 2- or 3-day conference—I have forgotten which—in which all of these or most of these gentlemen participated, in which we discussed the thing in great detail for many hours and hammered that out as the consensus of opinion and I participated in that conference and beyond that I had no further connection with it.

Senator DONNELL. Well, at any rate, you and Mr. Michael M. Davis, Mr. Channing Frothingham, and Dr. John P. Peters, are among those listed on the outside of that document as Health Program Conference, the report of which is contained in that pamphlet. That is correct, is it not?

Dr. Boas. Yes.

Senator Donnell. Now, Doctor, so you have had something do do, then, with the actual work of this Committee on Research and Medical Economics which published the book; is that right?

Dr. Boas. I was a participant in that conference; yes.

Senator Donnell. Yes. Now, that committee, as you say, consists of about 10 people and it got out this document here which I have referred to and of which copies can be ootained as I have indicated.

Now, you are also connected, are you not, with the Committee for the Nation's Health?

Dr. Boas. I am.

Senator Donnell. How large an organization is the Commitee for the Nation's Health?

Dr. Boas. I believe—and here again I cannot tell you accurately—that they have approximately 2,000 members.

Senator Donnell. Approximately 2,000 members?

Dr. Boas. I believe so.

Senator Donnell. Do you know that as a fact or not?

Dr. Boas. It is my recollection; I attended their last meeting and I think that is what was reported.

Senator Donnell. You are one of the members of the board of directors of that organization, are you not?

Dr. Boas. I am.

Senator Donnell. And Dr. Channing Frothingham that is listed on this pamphlet that I refer to, the report of the Health Program Conference, is another member of that board of directors, is he not?

Dr. Boas. Yes.

Senator Donnell. In fact, he is chairman of the Committee for the Nation's Health.

Now, Mr. Michael Davis, to whom I have referred in connection with the Committee on Research and Medical Economics, is chairman, executive chairman of the Committee for the Nation's Health, is he not?

Dr. Boas. Yes.

Senator Donnell. And through Mr. Michael Davis in large part you associated yourself with the Committee for the Nation's Health, is that right?

Dr. Boas. Probably; I do not recall who invited me to join.

Senator Donnell. But you know that you have been closely associated with him in work of that particular organization, the Committee for the Nation's Health?

Dr. Boas. Yes.

Senator Donnell. Now, you are also, as you have indicated, the head of the Physicians Forum and this same Dr. Channing Frothingham is in that too, is he not?

Dr. Boas. Yes.

Senator Donnell. And as you have referred, as I have indicated, to the Physicians Forum—though as you have indicated subsequently—approximately two-thirds of the membership of that organization is within a belt of about 250 miles from the Atlantic coast.

You are also connected, are you not, with the Committee of Physicians for the Improvement of Medical Care?

Dr. Boas. I am.

Senator Donnell. And Dr. Frothingham is chairman of that, is he not?

Dr. BOAS. He is.

Senator DONNELL. And Dr. Peters is on the board of directors of that organization, is he not?

Dr. BOAS. Yes.

Senator DONNELL. The same Dr. Peters as on the Committee for the Nation's Health, is he not?

Dr. BOAS. He is.

Senator DONNELL. And the same Dr. John P. Peters is on the Committee on Research and Medical Care, the committee to which I have referred, is he not?

Dr. BOAS. I do not recall if he is on that.

Senator DONNELL. You do not recall being on the editorial board along with him—the Committee on Research and Medical Economics?

Dr. BOAS. He may have been; I do not happen to recollect.

Senator DONNELL. He is listed in this pamphlet as a member of this Health Program Conference?

Dr. BOAS. He was a member of that conference.

Senator DONNELL. Now, doctor, this Committee of Physicians for Improvement of Medical Care, that Mr. Michael M. Davis, did he have something to do with the organization of that?

Dr. BOAS. None whatsoever to my knowledge.

Senator DONNELL. None whatsoever to your knowledge. Are you sure that he did not?

Dr. BOAS. I was not a member of that committee when it was initiated.

I think I became a member some 4 or 5 years after it started. So I did not know anything about its origin.

Senator DONNELL. All right. At any rate, the relation between that committee and Mr. Davis is very friendly and very close.

Dr. BOAS. I am afraid not.

Senator DONNELL. Now, what I am getting at, Dr. Boas, that these various organizations with quite impressive names—Committee on Research and Medical Economics—getting out this type of publication with a total of 10 members. The Physicians Forum—I am not saying this in disparagement of your organizations, as to their quality, but the Physicians Forum containing 1,000 members, described as a national organization, containing only about one one-hundred-and eightieth of the membership of the physicians of the country; the Committee for the Nation's Health, and this Committee of Physicians for the Improvement of Medical Care, and all of them have been extremely active in connection with the Wagner-Murray-Dingell proposed legislation, have they not?

Dr. BOAS. Yes.

Senator DONNELL. What was the reason for formation of so many committees instead of just having one?

Dr. BOAS. I think I can outline that for you.

The Committee on Research and Medical Economics—I cannot tell you when it was established—but Dr. Davis used to be in Chicago with the Rosenwald Fund in the medical branch and when he came to New York, this committee was set up to continue research and medical sociology; and it is not a propaganda organization, so far as I know. It is a purely research organization.

Senator DONNELL. That is the Committee on Research and Medical Economics?

Dr. BOAS. Yes, sir.

I cannot tell you very much about it because I have not been in close contact with them except when I served on the editorial board of Medical Care.

The Committee of Physicians for the Improvement of Medical Care was organized; again I cannot tell you the exact date. But the foundation in Boston—the founder's name slips my mind—made a study of the status of medical affairs and the reactions of physicians on the state of medical affairs and published two volumes entitled "American Medicine." That must have been some 10 or 12 years ago. I do not recall exactly when that was, and in those two volumes, a very large number of physicians expressed their dissatisfaction with things as they were and as a result of that largely, I believe, a group of physicians, a small group, approximately 20 or so, who I think are, all of them, professors of universities, organized the Committee of Physicians for Medical Care and got out what they called the Principles and Proposals, and sent it out to doctors and got a group of some four or five signatures who approved these principles.

That committee has continued since, and they meet approximately once or twice a year when they discuss issues which they think are important and try to analyze them objectively and publish statements in regard to them, and they publish many statements on health legislation in Congress.

The physicians' forum started as a purely local group in the New York Medical society.

The immediate stimulus for it was an amendment to the constitution of the State society of New York which would have provided that no doctor would be permitted to give public expression to any views on the social aspects of medicine which were at variance with the particular dicta of the board, the board of trustees of the State society.

When this amendment came up in the New York society, a group of us were so indignant about this restriction of free speech that we fought it and we succeeded in defeating it and out of that informal group grew a group which continued to function to oppose what we thought were unfortunate tendencies in the county society.

Then, when the first Wagner bill was introduced in Congress, we began studying the national scene and this whole problem of medical care and medical insurance. At that time there were many different opinions in our group.

Senator SMITH. Do you remember when that was, the first bill?

Dr. BOAS. I think it was 1939. I am not absolutely certain.

Senator SMITH. We can find that out. I just thought you might remember. I am trying to get the chronology of this development.

Dr. BOAS. And for a year we fought among ourselves as to whether we wanted to back compulsory health insurance and we finally voted to do so and we feared at the time we might disrupt our organization; but as a matter of fact, only a handful of doctors left us and then we saw that we would have to function on the national scene and we changed our name from the New York Physicians Forum to the Physicians Forum and we have gone on since then.

The Committee for the Nation's Health was formed, I believe, because there used to be an organization called the American Society for Social Security or something to that effect, of which Mr. Abram Epstein was secretary. That was quite an old organization and they interested themselves in all types of social security and old-age security and the like—unemployment security as well as health.

They were very active in the early thirties before the social-security legislation was passed.

Senator SMITH. They were not physicians, necessarily? There were among them social workers?

Dr. BOAS. Laymen, economists, and the like.

And when Mr. Epstein died, the organization gradually disintegrated and there was no organization representing the public which interested itself in the social-security approach to medical care and the Committee for the Nation's Health was organized in the hope of carrying on the work in the field that this old society had been carrying on and addressed itself primarily to the layman.

Senator DONNELL. Have you finished, Doctor?

Dr. BOAS. Yes, sir.

Senator DONNELL. Now, Doctor, these various organizations, particularly the Committee on Research and Medical Economics, the Committee for the Nation's Health, and the Physicians Forum, have been constantly in consultation with Mr. Michael M. Davis; that is right, it is not?

Dr. BOAS. Well, that could be answered in a general way, Senator Donnell. Of course, I run into Dr. Davis quite often and at times we discuss various specific problems. But Dr. Davis, for instance, has never attended any function or meeting of the forum. He has absolutely nothing to do with its administration or organization, plans, or anything else; as a matter of fact, we have from time to time had very sharp differences and except insofar as we are both interested in ultimate ends we have no direct connection with them.

Senator DONNELL. You and he are both interested in the Wagner-Murray-Dingell legislation and are strongly in favor of it; that is correct, is it not?

Dr. BOAS. That is correct.

Senator DONNELL. And Mr. Davis is in turn a consultant to the Director of the Bureau of Research and Statistics of the Social Security Board; you know that to be a fact, do you not?

Dr. BOAS. Yes.

Senator DONNELL. Do you know Dr. Anna Rand?

Dr. BOAS. Yes.

Senator DONNELL. She is connected with the Physicians Forum, the District chapter, is she not?

Dr. BOAS. That is right.

Senator DONNELL. Do you remember a meeting of this District chapter that was held on or about January 26, 1946, at which there was organized a group, to quote the Washington Post, to sell the District and the Congress on compulsory health insurance—do you remember that?

Dr. BOAS. No, sir.

Senator DONNELL. Well, you knew about that meeting, did you not, the fact that such a group had been organized?

Dr. BOAS. I do not recall the specific reference.

Senator DONNELL. Do you know or did you ever learn of the fact that such a group had been formed?

Dr. Boas. Is this an independent group?

Senator Donnell. This is a group that was formed at a meeting of the Physicians Forum, District chapter, on January 16, 1946, and the group consists of Dr. Dorothy Ferebee, Dr. Irving Winik, Dr. Rand, and Rev. Francis McPeek, Benjamin Asia, and Miss Margaret Stein who I believe is here this morning in this room. You are acquainted with Miss Stein? She was here this morning and conferred with you?

Dr. Boas. I am acquainted with Miss Stein.

Senator Donnell. You are now very active in connection with advocacy of the Wagner-Murray-Dingell bill?

(Response from the floor.)

Senator Donnell. Milton I. Roemer?

Dr. Boas. Yes.

Senator Donnell. He is a member of the Public Health Service, is he not?

Dr. Boas. He is.

Senator Donnell. And do you know whether or not he has been likewise active in connection with the Wagner-Murray-Dingell legislation; do you know?

Dr. Boas. I know no details about it.

Senator Donnell. Now, Doctor, your organization, the Physicians Forum, particularly, has been here in Washington? It was here last year in advocacy of the Wagner-Murray-Dingell bill and you proposed to continue your advocacy of it, did you not?

Dr. Boas. We propose to continue our advocacy of national compulsory health insurance.

Senator Donnell. All right; and you regard this bill, S. 1320, as a proper bill to effectuate that purpose?

Dr. Boas. With certain modifications.

Senator Donnell. All right, and have you raised any funds at all for the purpose of securing the passage of this legislation, S. 1320, or the defeat of S. 545?

Dr. Boas. No, sir. The only funds we have are those of maintaining our organization.

Senator Donnell. Well, there was a special grant of $10,000 given to the forum for the promotion of the Wagner-Murray-Dingell bill was there not?

Dr. Boas. That was approximately a year and a half ago.

It was for the general purposes of forum which at that time included advocacy of the Wagner-Murray-Dingell bill.

Senator Donnell. You have seen the minutes of the meeting that was held at a hotel at 156 East 56th Street, New York city, November 15, 1945, and the treasurer's report set forth therein quoting Sidney M. Greenberg who stated that special grant of $10,000 had been given to the forum for the promotion of the Wagner-Murray-Dingell bill:

> It has enabled us to add office staff. A major part of this fund has been already spent. This grant was specific for work on this legislation and has not been used for general activities.

I should say if you did not see those minutes that that does correctly recite the facts you know. That is correct, is it not?

Dr. Boas. That is correct.

Senator Donnell. Now, Doctor, in 1945, the Physicians' Forum had approximately $1,000 income, did it not?

Dr. Boas. I believe so.

Senator DONNELL. You had quite a money-raising meeting there at the Hotel Waldorf-Astoria, April 11, 1946; that is true, is it not?

Dr. BOAS. Yes.

Senator DONNELL. Have you raised money this year already for the support of the Wagner-Murray-Dingell bill?

Dr. BOAS. We have only raised money for the support of the forum. Our budget is about $1,000 a month, and we have run no special affairs. We have gotten contributions from members; we have gotten dues and we have gotten contributions from members and some contributions from laymen.

Senator DONNELL. Well, you have issued a bulletin, the Physicians' Forum has, under date of March and April 1947, have you not, in which there is set forth what is entitled an article "Double Standards in Medicine," the forum analysis of S. 545, the health bill introduced by Senators Taft, Smith, Ball, and Donnell. You have issued that, have you not?

Dr. BOAS. Yes.

Senator DONNELL. That has been widely circulated, has it not?

Dr. BOAS. The bulletin has a circulation of approximately 2,000.

Senator DONNELL. Any channeled to Washington?

Dr. BOAS. I suppose so.

Senator DONNELL. Now, Doctor, let me ask you, has your organization, the Physicians' Forum, registered, or are you personally registered here under the provisions of the La Follette-Monroney Act, particularly the Federal regulation of lobbying?

Dr. BOAS. No, sir.

Senator DONNELL. You have not registered under that?

Now, this incident that I am mentioning here, the Hotel Waldorf-Astoria, was before this Lobbying Act went into effect; but at that particular affair you raised about $6,000, did you not?

Dr. BOAS. Something like that.

Senator DONNELL. And in the minutes of November 11, 1945, that is ahead of the La Follette-Monroney Act—I want to be clear on that—he reported that, in addition to the special grant of $10,000, another grant was given to the forum of $1,500, which enabled you to print 50,000 copies of the pamphlet, 49,000 of which had already been distributed; that is correct, is it not?

Dr. BOAS. Yes.

Senator DONNELL. And you noted that the CIO had purchased some 5,000 of the pamphlets I referred to and the A. F. of L. purchased 10,000 copies?

Dr. BOAS. Yes, sir.

Senator DONNELL. As a matter of fact, the purpose of all of these organizations, and particularly this Physicians' Forum, is to aid in the passage or defeat of legislation; that is right, is it not? For that purpose in the National Congress?

Dr. BOAS. That is the ultimate purpose; but we feel that the only way we can achieve that purpose is through education, more of the layman than of the doctor.

Senator DONNELL. Now, in your Physicians' Forum Bulletin of January and February 1947, at page 3, you say this—or rather the organization did:

> The bill introduced by Senators Taft, Smith, Ball, and Donnell * * * the provisions are but a drop in the bucket. We must redouble our efforts to promote

> compulsory health-insurance legislation which will guarantee to everyone good medical care when he needs it, without having to plead poverty or deprive himself of other necessities.

Would you state whether or not, Doctor, you have considered whether your organization is a lobbying organization which comes under the terms of the La Follette-Monroney bill?

Dr. Boas. It had not occurred to me. I would be glad to be enlightened in that respect. I was under the impression that lobbyists were employees of organizations who made their headquarters in Washington and had continuous or repeated personal interviews with individual Members of Congress and tried to persuade their votes. We have restricted ourselves to educational material and speeches and talks and the like.

Senator Donnell. I do not find anything in the act which sustains your view that it was applicable only to persons maintaining themselves here in Washington.

Section 307 of the act reads:

> The provisions of this title shall apply to any person, except a political committee as defined in the Federal Corrupt Practices Act, and duly organized State or local committees of a political party, who by himself, or through any agent or employee or other persons in any manner whatsoever, directly or indirectly, solicits, collects, or receives money or any other thing of value to be used principally to aid, or the principal purpose of which person is to aid, in the accomplishment of any of the following purposes: The passage or defeat of any legislation by the Congress of the United States; to influence, directly or indirectly, the passage or defeat of any legislation by the Congress of the United States.

Now, I am not advising you as to your legal obligations; I am asking what are the facts, whether or not you have registered, whether you consider that you should register, and whether the primary purpose of the Physicians Forum is the influencing of the passage or defeat of legislation in Congress.

Now, I call to your attention a letter which is before the La Follette-Monroney bill. I do not want to mislead you in that connection. The letter of August 27, 1945, is from yourself, addressed to "Dear Friends," and the concluding paragraph of which reads:

> The Physicians Forum is also prepared to assist you or any organization interested in promoting passage of the Wagner-Murray-Dingell bill by furnishing press releases for local newspapers, recommending speakers for conferences or mass meetings and in other ways. We hope that you will call on us for help.

You sent that letter, did you not, widely, all over the country?

Dr. Boas. I must have.

Senator Donnell. I want to ask you just a very few questions on this particular legislation.

Now, you favor compulsory insurance; that is right, do you not?

Dr. Boas. That is right, sir.

Senator Donnell. And your point, as you make it here, on page 2 of your statement, is that legislation designed to meet the end which you desire to accomplish must do two things: One, insure the availability of complete medical care to all of the population; and, second, provide that the quality of such care be of the highest.

Now, Doctor, have you had occasion to examine into what is the history in other countries of the quality of the care that has been furnished under compulsory insurance plans?

Senator Smith suggests we get into the record first, if you could tell us, what countries do have compulsory insurance plans.

Dr. Boas. Great Britain has a compulsory insurance plan; the Scandinavian countries have; Germany had before the war, and they still have; I believe that France has. Many of the South American countries have.

Senator Donnell. How about New Zealand?

Dr. Boas. Yes.

Senator Donnell. That is enough to start with. How about Great Britain, and have you investigated what the success or failure has been in Great Britain with respect to the quality of the care that has been brought about under the compulsory insurance plan?

Dr. Boas. From what I have been able to gather from reading, the medical care for the people in England, for the people who are reached by their compulsory health insurance, is infinitely better than it was before the insurance act went into effect but it is by no means ideal and that is the reason why they are planning to change it now. But they are changing it by expanding it and not by contracting it.

Senator Donnell. Of course, there has been change in the government in Great Britain and in the last year or two in regard to the particular party that is in control.

Dr. Boas. Yes.

Senator Donnell. There is a nationalization in process there; you are familiar with that?

Dr. Boas. Certainly.

Senator Donnell. And is not the compulsory health insurance but one of the instances of this nationalization or, if you do not take offense at it, the socialization process in England; is that not true?

Dr. Boas. It undoubtedly is; yet the medical profession there itself favors the change in principle. They oppose certain detailed administrative aspects of it. But the medical profession itself in England has said, We must have complete coverage and we must have complete medical care for everybody.

Senator Donnell. On what points are the medical people in England at variance with the system there?

Dr. Boas. Largely in the method of payments, I believe.

Senator Donnell. Are you familiar with the work of Mr. J. G. Crownhart, secretary of the State Medical Society of Madison, Wis., his volume entitled "Sickness Insurance in Europe"? Have you read that?

Dr. Boas. I have not read that.

Senator Donnell. You know of his reputation, do you not?

Dr. Boas. I have heard it.

Senator Donnell. And you know that the book stands well?

Dr. Boas. I really do not know, sir.

Senator Donnell. You do not know about that? May I put into the record at this time, and ask you whether or not you have any views contrary to this—on page 64 of that book is the following:

> Again and again, the observer is impressed that the standards of medical and hospital service in Europe are not generally those of America.

May I pause to ask you, Is there compulsory health insurance in Denmark?

Dr. Boas. There is a form of compulsory health insurance.

Senator **Donnell.** I continue with Mr. Crownhart's observations:

> The director of one of the large public health institutes in Denmark pointed to this fact and referred to a lessening in the quality of teaching service in their medical school as one of the byproducts.
>
> Sickness insurance is a leveling device—

said this professor who had visited this country on occasion.

> It assures the mediocre physician just about the same rewards as he who would give an outstanding service if he were to have time. The incomes tend to be leveled, but that is not all—the tendency over the years is to level the services to something that is neither bad nor good. But the incentive is gone and we develop fewer brilliant minds in our teaching centers and America captures the lead in health and methods to regain it.

Do you concur in that view set forth in this excerpt from Mr. Crownhart's work?

Dr. **Boas.** No; I do not.

Senator **Donnell.** Have you been over in Great Britain?

Dr. **Boas.** Not in many, many years.

Senator **Donnell.** Have you studied personally over in Great Britain, the success or failure of their compulsory insurance plans?

Dr. **Boas.** I have not.

Senator **Donnell.** Have you been in Germany for that purpose?

Dr. **Boas.** Not for that purpose.

Senator **Donnell.** Have you made any study of Germany as to the success or failure of their system?

Dr. **Boas.** No.

Senator **Donnell.** Same question as to France.

Dr. **Boas.** I have no first-hand studies of these plans in other countries.

Senator **Donnell.** And that is likewise true in New Zealand, and you have made no study there?

Dr. **Boas.** That is right.

Senator **Donnell.** You know, do you not, that New Zealand is the country in which there has been a very great deal of criticism with respect to the operation of compulsory insurance plan; you know that, do you not?

Dr. **Boas.** Yes.

Senator **Donnell.** You have seen that in the New York Times, have you not?

Dr. **Boas.** Yes, sir.

Senator **Donnell.** It speaks of articles which have appeared therein from correspondence from New Zealand; that is correct, is it not, Dr. Boas?

Dr. **Boas.** Yes.

Senator **Donnell.** Now, Doctor, in regard to this matter of State and Nation, you have referred in your testimony to the emphasis that is placed in this bill, S. 1320, on decentralization of the administration of the act. You do not at all contend, do you, Doctor, that S. 1320 leaves it up to the States as, for illustration, to who is eligible under the bill for hospital and medical benefits; you do not mean that is left to the States?

Dr. **Boas.** No.

Senator **Donnell.** It is true, is it not, that there are somewhat elaborate provisions entitled "State Regulations" or something of that kind, in the bill—"State Administration" but the ultimate decision rests, under S. 1320, in substantially every instance, does it not, Doctor, with the Federal authority?

Dr. **Boas.** Are you referring to eligibility now, sir?

Senator **Donnell**. Eligibility and practically every question of ultimate importance in the bill; is that not true?

Dr. **Boas**. Undoubtedly the eligibility and the broad standards under which the care should be given is set by the Federal board.

Senator **Donnell**. Yes. For instance, Doctor, I call your attention, at page 48 of S. 1320, to the following:

> Nothing in part D of this title shall be deemed to require or authorize any assumption by the State agency, designated in accordance with an approved State plan of operations approved under such part, of any of the Administrator's responsibilities under this section, but the Administrator may utilize existing facilities and services of any such agency on the basis of mutual agreements with such agency.

You are familiar with that portion of the bill, are you not?

Dr. **Boas**. Yes.

Senator **Donnell**. Now, Doctor, let me just illustrate without going into too much detail on it—at page 7 of S. 1320, down at the bottom of page 6, it defines what hospital services consist of.

> Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board, hereinafter referred to as the "Board," after consultation with the National Advisory Medical Policy Council, hereinafter referred to as the "Advisory Council" by regulation designates as essential to good hospital care, for a maximum of sixty days benefit in any benefit year.

You are familiar with that provision in S. 1320?

Dr. **Boas**. Yes.

Senator **Donnell**. I point these things out, Doctor, not because of any question there might be about the benefit, but in order that the record may be perfectly clear that while, as you have indicated in your statement here this morning, there is considerable emphasis placed in the wording of S. 1320 on State administration, and I pause for correction if I am wrong—in every fundamental point, the ultimate decision as to what shall be valid and what shall be good practice and who shall be eligible and what shall constitute hospitalization, rests not with the State but with the Federal Security Administrator; that is right, is it not?

Dr. **Boas**. I believe so; yes, sir.

Senator **Donnell**. Now, Doctor, the Federal Security Administrator, for instance, is given, at page 47, this authority:

> The Federal Security Administrator, through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determinations as to the eligibility of individuals for benefits under ths title.

You are familiar with that, are you not?

Dr. **Boas**. Yes.

Senator **Donnell**. Now, you are familiar also with the fact, are you not, Doctor, that the Federal Security Administrator is not a physician at the present time at all, is he?

Dr. **Boas**. That is right; no.

Senator **Donnell**. Mr. Watson Miller?

Dr. **Boas**. Yes.

Senator **Donnell**. And you are familiar with the fact that at page 39, and I am quoting, it is provided, in S. 1320, and I quote:

> tion and supervision of the Federal Security Administrator. The Board shall

perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

You are familiar with that, are you not?

Dr. Boas. Yes.

Senator Donnell. Now, Doctor, therefore the ultimate power under this bill heads up, notwithstanding all this emphasis that is placed on State administration, heads up finally through a Board; but the functions of it, that Board, to be administered under not only the supervision but the absolute direction and supervision of the Federal Security Administrator of the Federal Security Administration who is not required, under the law, to be a doctor and who, as a matter of fact, at the present time, is not a doctor; that is right, is it not?

I so understand this bill, S. 1320, instead of following the plan that Senator Smith has indicated here of giving grants to the various States of the Union, in order that they may work out State plans locally, we find that notwithstanding these provisions in S. 1320 about State administration, that the ultimate power comes right back down from the Pacific coast to this country and the Atlantic coast and the northern boundary and the southern boundary, right in here to Washington through the channel of a Board into one man's hands, the Federal Security Administrator, and that one man not a doctor at all. Now, that is true, is it not?

Dr. Boas. Yes; that is true.

Senator Donnell. Now, Doctor, there is, therefore, a very material difference between the fundamental principles of these two bills; you personally favor this national idea of channeling all back here through Washington and allowing this one man to have the ultimate power on this matter of importance in the administration of this compulsory health insurance. You are in favor of that plan under S. 1320?

Dr. Boas. I think it is not quite fair to say that all this power is channeled into the hands of this one man because after all it will actually be in the hands of the Board. This one man has various other responsibilities, too, and cannot possibly attend to the details of administration of this plan.

Senator Donnell. That is true. If I may interpret you—you cannot attend to all, or he cannot attend to all details himself, so you may even go one step further and say that as a practical proposition, to quote this bill, S. 1320, "all functions of the Board shall be administered by the Board"—that is every function, not just some isolated minor ones, but all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator—and you have said, it is a physical impossibility, or as you have said in substance, it is a physicial impossibility for that one man to do it all; so he is going to delegate it to people not even mentioned in the bill, is he not?

Dr. Boas. I should imagine he would delegate to the Board, would he not?

Senator Donnell. Well, is there anything, Doctor, that says that he shall delegate these functions that are under discussion, that are under his direction and supervision, to any particular individuals or any particular Board. Is that right?

Dr. Boas. Not to my recollection. Yet the board is given specific responsibilities and duties.

Senator Donnell. Yes; they are given various responsibilities and duties, but the ultimate cap sheaf in the bill, with respect to that, the language that I have quoted, is "that all functions"—page 39—"all functions of the board shall be administered by the Board under the direction and supervision of the Federal Security Administrator."

Dr. Boas. Is that not rather analogous, shall we say, to a Cabinet officer's responsibility for everything that goes on in his department?

Senator Donnell. I do not think so, Doctor; I think where you have a member of the Cabinet, he is the man responsible for that work and it is centered in him; but here you have been talking about State administration, and you have been emphasizing, as I have understood your testimony, and if I am quoting you incorrectly I want to be corrected—I understood your testimony to indicate that this bill differs from the bill of a year ago, S. 1606, very largely in this matter of increased emphasis on State administration and decentralization and all that.

The point I am making is that there is no fundamental difference whatsoever in that bill, S. 1320. This one sentence—if there was not another sentence in the bill—"All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator" certainly vests all the national authority not in the Board, not in the Advisory Council, not in the States, not in any State administration, but in one man, the Federal Security Administrator, who is not a doctor and does not have to be a doctor under the law.

Now, if there is anything incorrect about that statement, I would be very glad to have you correct it.

Dr. Boas. Factually, you certainly know the facts in this bill.

Senator Donnell. The facts are as I have related them, are they not?

Dr. Boas. Yes. Your statement is certainly technically correct, but I do not think it would work in the sense which you indicated and I do approve of setting Federal standards irrespective of the bill. I am convinced that if a thing like this is to work properly, broad Federal standards have to be set and that within the framework of those broad standards very considerable local autonomy is possible.

Senator Donnell. I do not want to take much more time. I have an idea our chairman feels we are going to have to be moving on to other witnesses; I will push on.

Doctor, we have talked about a national health insurance board. In S. 1320, let us analyze for a minute; take section 251 (a) on page 38, at the bottom of the page.

By the way, before I proceed to that, I want you to turn, if you will, to that page I have been reading from, page 39; I want you to see that I have quoted that correctly. Down at the bottom of page 39 where it says, line 22—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator

I want to be sure that is a correct quotation.

I want you to turn back to the preceding page, page 38, and just observe for a minute what this board is that you have been talking about. It says, does it not, that—

> There is hereby established in the Federal Security Agency a National Health Insurance Board—

That, by the way, is the agency of which the Federal Security Administrator is the head—

> to be composed of five members, three of whom shall be appointed by the President by and with the advice and consent of the Senate.

Now, let us just see what those five members are, who they are, and what they have to be, if anything—five of them, appointed by the President, by and with the advice and consent of the Senate.

Now, the other two are automatically defined right here—

> The other two of them shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security.

There is no requirement that you know of by law, is there, that the Commissioner for Social Security shall be a doctor?

Dr. Boas. No.

Senator Donnell. All right; the Surgeon General of the Public Health Service is a doctor. I do not know what the statutory qualifications are, but obviously he is a doctor. That only leaves three to be appointed by the President.

We start out here with one doctor, the Surgeon General. Now, the only provision I find down in this section or anywhere in the bill that I have observed, with respect to the qualifications of any of these three members to be appointed by the President are these:

> At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States.

I do not think any provision even as to how long he shall have been licensed—a day or a year or 10 years—but the point I make—and if I am incorrect, if you will call my attention to it—is that the National Health Insurance Board consists of five men and it has the compulsion of having only two doctors on there, one of whom is the Surgeon General of the Public Health Service and one of whom is a doctor of medicine licensed for any period, small or large, to practice medicine or surgery in one of the States, so that out of this National Health Insurance Board consisting of five members, only two of them have to be doctors; is that right? Is that how you construe it?

Dr. Boas. That is right, and I believe it is a good thing.

Senator Donnell. As a matter of fact, however, that is all it has to be.

Dr. Boas. Yes.

Senator Donnell. Now, I wanted to call your attention also to this other organization, the National Advisory Council—there is quite a good deal of emphasis placed on that in this bill at page 42—the National Advisory Medical Policy Council. Well, now, that consists of how many members? It consists of 17 members, does it not?

Dr. Boas. Yes, sir.

Senator Donnell. One of whom is the chairman of the Board. That is right, is it not—at the top of page 42?

Dr. Boas. Yes, sir.

Senator Donnell. And he serves as chairman of the Advisory Council ex officio.

Now, there are 16 other members. We start out here with one, the chairman of the Board, and 16 other members. Now, who appoints the other 16 members?

Dr. Boas. The Federal Security Administrator.

Senator Donnell. The Federal Security Administrator appoints 16 out of the 17 members of the Advisory Council, which is, of course, perfectly consistent with the fact that all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator; so it would appear, Doctor, would it not, that your Advisory Council which is not this National Health Insurance Board, but is a council, is an organization of 17 members, 16 of whom are appointed by the Federal Security Administrator who has the power of direction and supervision of all functions of this National Health Insurance Board?

So it ultimately works down to the fact that we start out with two boards and the National Health Insurance Board, of whom two have to be doctors, every function of which board is subject, subordinate, to the direction and supervision of the Federal Security Administrator; and we start out with a second board, this National Advisory Medical Policy Council, 16 of the 17 members of which are appointed by the Federal Security Administrator.

We start out with the further fact that—and this is the last sentence I am going to state for the present—start out with the further fact that notwithstanding all this emphasis on State administration, the ultimate power channels right back in certainly many of the major—and I would like for you to point out any major functions that are not in there—functions, back through all this channel back into one man's hands in Washington, the Federal Security Administrator, who is not required to be a doctor.

Now that is a correct statement, is it not, Doctor, regarding the State administration, the Advisory Council, and the functions of the National Health Board—National Health Insurance Board?

Dr. Boas. Your statement is certainly technically correct. I do not think it would work out in the sense you intimate because I still think there is allowance in the bill for vast State autonomy.

Senator Smith. Doctor, we are very grateful to you. Personally, I feel that you have helped bring out the differences between the two bills and the theory on which you are working very clearly; and we deeply appreciate your testimony.

Dr. Maurice H. Friedman.

(Dr. Boas submitted the following brief:)

Testimony on S. 545 and S. 1320 Before the Senate Committee on Labor and Public Welfare, June 25, 1947, by Dr. Ernst P. Boas, Chairman, the Physicians Forum, Inc.

I appear in behalf of the Physicians Forum, a national organization of doctors, which includes among its members general practitioners, specialists, university professors, research workers, and public health physicians. The purpose of the forum is to contribute to the improvement and wider distribution of medical care, and to educate physicians and laymen in regard to the medical needs of the country. We are concerned with the quality of medical care, as well as with its more adequate distribution.

At a meeting of the executive committee of the Physicians Forum held on May 26, 1947, a motion was passed to disapprove of S. 545, and to support in principle S. 1320, and to authorize a representative to appear before this committee in the name of the forum. This action of the executive committee was approved at the annual membership meeting held at Atlantic City on June 12, 1947.

The proponents of both of the bills that are before this committee recognize the many serious inadequacies of health services in the United States, as well as the fact that large segments of the population do not receive proper medical care. It is unnecessary for me to elaborate on the facts in regard to the medical scene in the United States. They were documented and presented in detail by the spokesman for the United States Public Health Service at the hearings held in 1946 on S. 1606 before the Senate Committee on Education and Labor. They are well summarized in the report of the New York Academy of Medicine's committee on medicine and the changing order, published in 1947 by the Commonwealth Fund under the title "Medicine in the Changing Order." I quote but two sentences from this report: "The poor and middle-income groups, being largely unable to pay for major medical expenditures, suffer financially or physically, or both, when serious or prolonged illness strikes" (p. 47). "Today we are confronted with grave inequities in the medical services available to large segments of the rural population" (p. 96).

Evaluation of the two bills under discussion rests to some extent on certain basic assumptions. One may believe that the unfortunate inequalities and deficiencies in the distribution of medical care are not a major responsibility of the community, and that they can be corrected by charitable doles to those members of society whose insufficient incomes prevent them from obtaining adequate medical care. Or one may believe that every member of the community has the right of access to proper medical care, much as he has the right, and indeed the duty, to obtain an education. The Physicians Forum is of the opinion that every citizen, regardless of income, is entitled to complete medical care. Advances in the science and art of medicine have outstripped, by far, the methods for making these health services available to the average man. This gap must be bridged, both for the welfare of the Nation, and for the preservation of our democratic ideals.

Legislation designed to meet this end must insure the availability of complete medical care to all of the population; and it must provide that the quality of such care be of the highest. I propose to discuss the two bills from these general aspects.

S. 545

The most important section of S. 545 provides for general medical services for families and individuals with low income. The meaning of "low income" is not defined; the definition is apparently left to the States. Evidently it is the indigent and the medically indigent who are to be provided for. Therefore, in order to qualify for Government assistance under this bill, self-respecting persons would be subjected to a means test. Determination as to who is eligible for total subsidy, who for partial, and who for none, would demand a complex, burdensome, and expensive administrative machinery. The reintroduction of the charity concept into the field of public health and medical care reverses the trend that has been gaining momentum for several generations, namely, to regard health and medical measures as services needed by all citizens, and to free them from the yardstick of financial need. Eligibility for benefits would depend in part on State regulations, in part on the amount of money appropriated by Congress. Senator Taft has estimated that the appropriation suggested in the bill would provide for from one-fifth to one-quarter of the population. Yet it is a well-established fact that at least 80 percent of the population cannot afford to buy complete medical care.

The bill provides grants in aid to the States, which must themselves appropriate an amount "at least equal to the Federal aid." The States may include in their contributions moneys already being spent by political subdivisions and by private institutions for medical care to the needy, so that the State's share of the expenditure need not represent any expansion of services. The lower-income States will be entitled to proportionately larger sums of money than the high-income States, but they must contribute as large an amount of money as they receive, no matter how poor or prosperous they may be. It is well known that many of our States cannot afford such an expanded health program. Nothing in the bill requires a State to embark on a health program or to request a grant in aid, so that it is quite possible that the poorest States, where the need is greatest, would fail to take much advantage of these Federal grants.

The total sum of Federal money appropriated in the bill is $200,000,000. Thus, the moneys available would be equivalent to about 8 percent of current expenditures for medical care, provided that the States matched every Federal dollar.

Administration.—At the Federal level a new agency, the National Health Agency, is established. This agency would be under the direction of a physician and would be concerned only with health matters. It would include at least seven separate and independent bureaus, of which the United States Public Health Service would be one. All medical-care functions would be under the direction of a separate Office of Medical and Hospital Care Services, headed by a physician "who has had at least 5 years of active medical practice." This provision would bar from consideration such men as the present Surgeon General of the United States Public Health Service and other men equally outstanding in the field of public health and medical care. The United States Public Health Service would be denied participation in the administration of the program of medical care, and the administration of preventive and therapeutic services would be divorced. As we pointed out before this committee last year, preventive and curative medicine, which are but two aspects of sickness control, are becoming merged, largely as a result of the reduced incidence of the infectious diseases, and the ever-increasing prevalence of the so-called degenerative diseases of middle and later life. Preventive medicine begins with measures of personal hygiene and health examinations instituted by the general practitioner. Furthermore, separation of prevention and treatment of disease makes for administrative difficulties, adds unnecessarily to costs, and operates to protect the vested interests of private medicine.

It has become an accepted principle that while physicians must direct the technical aspects of a medical care program, the public, through its government and elected representatives, should establish the broad policies under which it should operate. Yet the bill establishes a National Medical Care Council which is to be dominated by professional representatives in a ratio of 5 to 3.

Quality of medical care.—There are no provisions in the bill to ensure that the expenditure of Federal funds will bring high quality medical care to the recipients. The whole matter is left to the States; no basic standards or guiding principles are set forth. Once a State plan has been approved, all administration is left to the State. In each State there is to be a medical and hospital care advisory council; there is no insistence on consumer representation, but an explicit requirement that State medical and hospital associations be represented. No local advisory councils are set up; indeed there are no specific provisions for local, city, or county administration.

The bill authorizes payments to be made "by the State, to any voluntary health, medical, or hospital insurance fund, or other fund not operated for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor." Such granting of public funds directly to voluntary private agencies involves a vast transfer of authority and responsibility. Yet the bill sets no standards for the operation of these private agencies; sets no safeguards to control administrative costs, efficiency, or economy of operations, to protect the interest of the consumer, or to assure adequate services both quantitatively and qualitatively.

There is no provision for preventive or laboratory services; no definition of hospital, surgical, or medical services, so that any of these may be greatly restricted in scope. There are no prescribed standards for the participating physicians or other medical personnel; no definition of the role of specialists, no standards for hospitals. In fact there is a clause that states that "nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of the health services with respect to which any funds have been or may be expended under this title." The inevitable result will be that medical services, for the most part, will be disorganized and inferior. There are no significant provisions, direct or indirect, to encourage the maintenance of a high quality of care.

A medical care program must have assured appropriations year in and year out. There is no certainty that any of the funds authorized in S. 545 would ever be appropriated in fact. The bill merely indicates that Congress may appropriate these sums if it so desires. Thus the sums available for the medical care program would depend from year to year on the climate of opinion in Congress. If there were an economy drive vital medical services might be jeopardized. This illustrates an important difference between S. 545 and an effective national health program. Such a program can be assured only through the device of social insurance in which taxes collected on a broad base are earmarked for health purposes.

Our objections to S. 545 may be briefly summarized. It is not a national health program, and it sets patterns of legislation that go counter to principles developed by progressive medical and public health leaders during the past 20 years. It establishes the means test as a prerequisite for giving medical care, thus reverting to the outmoded concept of medical care as a charity to the needy. It sets no standards for such limited medical care as may be supplied under the bill, so that the poor, as today, will probably receive a kind of medical care inferior to that available to those who can afford to bay it. It turns over large Federal and State funds to private agencies with little or no control as to how they will be spent. It creates an artificial and costly barrier between methods of disease prevention and medical care. It is for these reasons that we disapprove of S. 545.

S. 1320

S. 1320 is a national health insurance and public health act. It provides for prepaid personal health service benefits to all but a few groups in the population of the United States, to be paid for by "sums equal to 3 percent of all wages received" plus a certain amount from general taxation, when appropriated by Congress. In other words, main reliance for financing is placed on social-security payments by most of the population, earmarked for a personal health services account.

We approve of this wide coverage, irrespective of income, for the need of Government action arises from the fact that the vast majority of people cannot afford to pay individually for adequate medical care. We believe in the social-security principle of payment, because this assures that sufficient moneys will be available year in year out for the payment of medical services; because each worker will be making his own payment toward the cost of his own medical care; because these payments will be apportioned to his ability to pay. We believe that because of the uneven distribution of wealth in the United States, both as between individuals and large geographic areas including whole States, the Federal Government must assume responsibility for collecting the necessary funds and setting the broad standards under which they should be spent. Another reason for Federal action is the increasing mobility of our population, through which the worker might lose his benefits when he moved from one State to another unless the health plan were national in scope.

Decentralization of administration is spelled out in great detail. It is the intent of the bill that the health benefits be administered, wherever possible, by the several States. Any State desiring to assume responsibility for the program in the State, may do so if it undertakes to provide personal health-service benefits in accordance with the regulations and standards set up by the national authority. But each State is given great latitude in the details of its administrative plan, and the national agency is enjoined from exercising any authority with respect to the selection or compensation of any individual employed by the State for the administration of the act.

In order that personal health-service benefits be made available in a manner best adapted to local practices, conditions, and needs, responsibility for administration of benefits is further decentralized by the delegation of authority to local communities. The local health-service areas are to be designated by the State. The local administrative agency is to be either an administrative committee which shall act with the advice of a local area committee. The majority on these committees shall be representative of the interests of the individuals who are eligible for benefits. The whole administrative set-up is such that there will be the maximum local autonomy, and full elasticity to adapt the administration to particular local needs, yet without sacrifice of high standards of medical care that will be set up by a national agency.

We have a few comments to make in regard to this plan of administration. We deem it inadvisable to permit local administration by a committee. Committees rarely make good administrative units. Furthermore such a provision would tend to divorce the activities of the health department from a proper connection with the medical-care program. If there were a single local administrative officer. he in most instances, might be the local health officer, who would serve both ends with profit to the community. In our opinion, the local administrative officer should in all instances be the local health officer—if we are to have a truly unified health-service program.

By the same token, we believe that principle authority at the national level should be vested in the Surgeon General of the United States Public Health Service, rather than in a board. It has been the experience of a number of national programs—recognized by Congress (Social Security Board and Surplus Property Board for example)—that board administration is unwieldy and ineffective, so that boards have been replaced by single administrators. Assurance of proper concern for the interests of all parties is given by the provision for advisory bodies at all levels, and by reports to the Congress.

Although there is explicit prohibition against discrimination in the bill, experience has shown that under State administration it may be difficult to enforce this policy in all States, particularly since the powers and duties of the State agency are to be subject to such righs of judicial review in the courts of the States, as the laws of the State may provide. Special thought will have to be given to administrative measures to insure that the personal health-service benefits are given without discrimination on account of race, creed, or color.

The inhabitants of Puerto Rico and the Virgin Islands are specifically excluded from the personal health-service benefits. Yet among them the need for medical care is probably greatest.

Quality of medical care.—High quality and complete medical care is made possible because the bill provides for all needed preventive, diagnostic, and curative services by a family physician of the patient's choice; services of specialists when required, hospital care, laboratory and X-ray services, usually expensive medicines, special appliances, and eyeglasses. Dental, home nursing, and auxiliary services are provided to the extent that funds and personnel will allow. In the establishment of minimum standards for certain professional personnel, the aid of professional advisory boards is enlisted. Special funds are set aside for medical research and the training of physicians, dentists, and other professional personnel. Special provisions are made to help solve the problems of rural areas, particularly those in which critical shortages of professional personnel and facilities hamper the development of adequate health services.

Physicians and dentists will both profit by the passage of this bill. Freedom of choice of physician is assured. Professional and financial incentives to practitioners to advance in their professions and to practice in localities where their services are most needed are provided for. Payments to physicians are to be adequate to give them assistance to pursuing postgraduate study, and to allow for adequate vacations. Unlimited opportunity for the development of group practice is given by the policy of utilizing organizations qualified to render services. This is fundamental, for group practice is, without doubt, the practice of the future.

We believe that the bill goes too far, however, in setting the policy to utilize, in the provision of services, almost any organization operating a voluntary health-service insurance plan or other voluntary health-service plan. Since most persons will be automatically insured, and their premiums paid through a national system, it seems quite unnecessary to employ the services of the many voluntary health-insurance plans now reaching a small fraction of the population. Administration entirely through public agencies would be far more efficient and less costly; this has been the experience throughout the world. Only actual professional service groups or well-organized hospitals and their staffs should, in our opinion, be utilized in this connection.

We regret that the fee for service method of payment of physicians is retained, for, as we pointed out last year, this system favors abuse and multiplies administrative difficulties.

We heartily approve of the provision for grants-in-aid for medical research and education, for the development and expansion of health services, for public assistance to be used for securing personal health-service benefits for the needy, and the modification of the present formula for making Federal grants for the construction of health facilities.

We endorse S. 1320, with the exception of the few items discussed above, because it establishes a true national health program, both for the prevention and treatment of disease. We support coverage of the vast majority of the people of the United States, and we approve of the social-security principle. The bill, while insuring that the medical care given shall be of high quality, gives great autonomy to individual localities to develop detailed professional arrangements best suited to their needs. Far from undermining personal relationships, S. 1320 breaks down the financial barrier between doctor and patient; it places the resources of modern medicine at the disposal of nearly all the people of this country. It permits the physician to develop his medical abilities to the greatest possible degree, and to place them at the service of his patients, irrespective of their financial circumstances.

Some claim that a national health-insurance program is less needed today than it was a few years ago, because there is prosperity and the people are tired of governmental activities. We are convinced that, with prices at an all-time high, and many signs of an economic recession ahead, the need for national security in health is as urgent as ever. We know, from the personal experience of our members, that the people of this Nation today are as greatly desirous of insurance for comprehensive medical care as they have been for many years. Only a Nation-wide program can meet the need, and we therefore urge you to enact such a program without further delay.

STATEMENT OF DR. MAURICE H. FRIEDMAN, WASHINGTON, D. C.

Senator SMITH. Dr. Friedman, before you begin your testimony, would you be good enough to state for the record your background and your qualifications as a witness to testify in this matter?

Dr. FRIEDMAN. Yes, sir.

For the record, my name is Maurice H. Friedman, a physician engaged in the practice of internal medicine in the District of Columbia. I represent no group or organization. For about 10 years I was a full-time member of the teaching faculty of the University of Pennsylvania Medical School where as assistant professor of physiology my activities were concentrated on teaching and research in physiology and experimental medicine. For over 4 years I was an internist and consultant in gastro-enterology in the Army Air Forces.

I represent no group and no organization.

Neither my time nor your patience would permit the reading of my entire testimony which I have written in the form of a memorandum.

I should like first the privilege of inserting the entire memorandum as a matter of record with, however, the notation that the copies which have been distributed have a few typographical errors which I have corrected in a master copy which I should be pleased to leave with the committee or its representative.

Senator SMITH. Doctor, just let me ask you this. We will be pleased to have your mimeographed statement in the record, but what we are getting at here, of course, is your testimony with regard to S. 545 which is before the committee.

So far as S. 1320 is concerned, what we want to bring out is any difference between S. 1320 and the Murray-Wagner-Dingell bill of last year, S. 1606, because we had 31 days of testimony, as I understand it, on S. 1606 last year and I do not want to duplicate our testimony too much because we will print the statement, and while we want every witness to include anything he wishes, I want to avoid, at the instance of economy, any duplication. So I will ask you if you will be good enough, in presenting the statement to the reporter, to eliminate duplications of testimony, we would appreciate it.

Dr. FRIEDMAN. I had that in mind in the preparation of the comments which I should like to call to your attention.

My purpose in presenting the memorandum and my testimony are not primarily to deal with the detailed provisions of either bill.

My chief purpose is to call the attention of the committee to some facts and some aspects of the data which have heretofore been presented in support of either or both bills, aspects of these data which have not to my knowledge ever been presented to this committee and I think are germane to the present discussion.

The two bills now before Congress start out with two different basic assumptions. The proponents of compulsory health insurance have assumed that the status of our national health is in such precarious position that there is an urgency about drafting legislation to immediately cover the entire country with some improved from of medical care.

Those persons who, on the other hand, support S. 545 proceed on the assumption that there is no such urgency, no such urgent situation, that we do have time for further wise and cautious experimentation so that in the end a wise public policy may be drafted.

My only testimony for the moment shall be addressed to whether or not such urgent situation exists.

Probably no set of statistics have been more emphasized or more frequently stressed by the proponents of compulsory health insurance than the country-wide draft rejection figures.

I should like to call your attention to some aspects of this problem.

I have made, to the best of my ability, an analysis of the kind of defects which are uncovered by those rejections and without bothering you with detailed analyses which you may see in my memorandum, we come up finally, after bending over backward to make all sorts of allowances for those which might have been corrected, with a total of 18 to 20 percent for all cases of rejection which could have been influenced conceivably by medical care.

In order that that total of 18 to 20 percent of defects could have been prevented or corrected, we must make the following assumptions: We must assume that every person with such defect could have been induced to come before a medical man for some attention.

Senator SMITH. Doctor, for the record, right there, I would like to have you state what the percentage of rejections was, if you remember, compared with the total selected.

Dr. FRIEDMAN. The total rejections were 36 percent for the years of which I am talking—1941 to 1943.

Senator SMITH. Of all men presented for examination for the service?

Dr. FRIEDMAN. That is right.

Senator SMITH. Thirty-six percent were rejected.

Dr. FRIEDMAN. May I just inject one thing here?

Senator SMITH. Just for the record, to make it perfectly clear.

Dr. FRIEDMAN. I should also like to make it clear that the population which was examined by the draft boards was not entirely truly representative of the male population of this country.

Over two and half million men volunteered; they were physically fit. If those men had been added to the total we are considering, the rejection would have automatically dropped from 36 to 28 percent. Of those men who were left out of the total pool of available manpower, over a third were granted immunity either because of their particular value to their industry or because they were on the farm.

In other words, this is not a true statistical cross-section of the male adult population of the United States.

Senator SMITH. Is the last third you referred to classified as rejects?

Dr. FRIEDMAN. No, sir; they never came before the boards for examinations.

My point is that this group that came before the board for examination was a selected group, selected from those who did not volunteer on the one hand and eliminating those who were granted deferments because of their particular value to the community or to the family and that is what we have left.

Senator DONNELL. Do those facts appear in your statement as well? They are exceedingly interesting.

Dr. FRIEDMAN. They also appear in my original statement and the Selective Service Bulletin which I have here. They are perfectly cognizant of that and that fact has never been brought to the attention of this committee.

In order to reach, if you are talking about those rejections at all—in order to reach that figure of 17 to 20 percent——

Senator DONNELL. Is that the one entitled "Medical Statistics, Bulletin No. 3, Physical Examinations of Selective Service Registrants During Wartime, an Analysis of Reports for"——

Dr. FRIEDMAN. Yes, sir.

To return, if I may, to the testimony, we must return, in the first place, to reach a rejection rate of 10 to 20 percent that could have been charged to medical care and only to medical care. We would have to assume that every person with such defect could have been induced to get medical attention.

Secondly, that in every case the physician would recommend some kind of corrective measure;

Three, that every patient would take that recommendation and say, "Yes, Doctor, I agree; I will have it done," including major surgery, and what-not, and that is a job—that every recommended procedure would have been 100 percent effective.

Now, if you make all those assumptions, it is conceivable that 18 to 20 percent of those defects could have been prevented by the medical profession.

Of course, such an assumption, or such assumptions are not consonant with our every day experience in life.

Senator SMITH. That is 18 percent of the total or 18 percent of the 36 percent?

Dr. FRIEDMAN. Eighteen percent of all those rejected; precisely, 18 percent of 36 percent. Yes, sir.

Senator SMITH. That is what I wanted to get.

Dr. FRIEDMAN. I have not the time to discuss all of these details. They are in the testimony. There is one important point which has been expressed by the proponents of the compulsory health insurance bill and that is the Negro, because of his lower economic status, because of the fact that a large percentage of Negroes lived in the rural South, that they have lacked adequate medical care.

In regarding the differential rate of rejection of the white men and the colored men, indeed, Senate Reprint No. 4 of the Seventy-ninth Congress, which I believe was prepared under the direction of Dr. Falk, these differentials leave no doubt that these rates were as high as they were because of past medical neglect.

I should like to examine now in more detail the rejection figures for Negro registrants from the selective service boards. From this same bulletin which we have referred to a few minutes ago, you may notice that there are listed such items as mental deficiency which accounted for approximately 60 percent of all rejections of Negroes.

There is one medical condition for which the Negro suffered a greater rejection than the white man; that is under the heading of cardio-vascular disease. The selective service bulletin is careful to point out that the reason for higher rejection rates of the Negro in this one category were due almost exclusively to the higher incidence of high blood pressure.

It is my sincere belief that the medical profession can do nothing about the onset of high blood pressure. We are not prepared. We have no means at our hand to prevent it. Indeed, our methods of treatment leave much to be desired; so there is one instance where past medical attention could not have prevented the onset of this condition. With the exception of educational deficiencies, venereal disease and this one category of cardio-vascular disease, which immediately boils down to high blood pressure in every single category of defect. the Negro showed a lower rate of rejection than the white man, not only slight, but very significantly lower.

You may find these data reproduced in table VII I have made in page 9 of my memorandum and if you please, you may look at those which are amenable to medical treatment or even dental treatment. If you look at teeth, there are approximately 125 defects for the white man and 47 something for the Negro.

Under "Nose," about 30 for the white man and 6 for the Negro.

Under "Tuberculosis" you have 19.9 for the white man and 14.6 for the Negro. Under "Hernia" which is a condition which could be repaired if we desired, 52.1 to 40.2 for the Negro. Hemorrhoids, another one, 11.6 versus 9.1.

You can go into the list. "Neoplasms" is perhaps an unfortunate term. You will find by detailed analysis of this bulletin of selective service that neoplasms were pilonidal cysts, a congenital cyst, and not cancer at all, but under the term of neoplasm. This can be corrected if the surgeon thinks wise—the white man at 10.2 and the Negro at 4.9. In fact, you could not find a single defect, with the exceptions of those I have named, which were as high in the Negroes as they are in the white man.

I am not using these statistics, or should not attempt to use them to indicate that the Negro is getting one kind or another of medical care.

However, if I were to use the same kind of logic as has formerly been used by some of the proponents of compulsory health insurance, we would conclude from statistics that the Negro is getting better care than white men.

That conclusion, of course, is not defensible.

The point I wish to make is that a listing of these defects has very little bearing on the status of our national health.

They have no real relevance to the discussions now before Congress and they have no place in any honest discussion of the merit of one bill or the other. They should be used neither for the support nor against one bill or the other. In other words, they are not relevant.

Senator SMITH. Is it possible to generalize at all as to reason why these figures show such lower—so much lower percentages for the Negroes in so many instances than for the white? If it is not possible to generalize, I do not want to take your time.

Dr. FRIEDMAN. I am not sure I could do that adequately and completely.

Senator SMITH. Very well.

Dr. FRIEDMAN. We have always been deluged with the arguments that there is a very real economic barrier to medical care in this country. I am not denying the existence of any economic barrier, but I do not think any calm, judicious analysis of the data would support the kind of barrier which we have been led to believe by the propoents of compulsory insurance exists.

The claim has been made that the volume of care, that volume a family gets, is largely, if not wholly dependent on the family income, that at least 40 percent of the population are entirely without medical care or dental care.

It is also claimed that the incidence of illness is highest in the lower income families.

That data is not altogether clear, gentlemen. I should like to have you refer to my table on page 15, table 13, where incidence of illness is related to family income. These data are taken from Falk, Klem, and Sinai and the data are to the best of my knowledge, faithfully reproduced there.

According to these data, the incidence is lowest in low-income families and rises progressively in high-income families, to be highest with highest income.

Senator DONNELL. I have here a book entitled "Costs of Medical Care," by Falk, Rorem, and Ring.

Dr. FRIEDMAN. That is pertinent, but not to this point. This is on incidence of medical care; it is Falk, Klem, and Sinai, University of Chicago Press, 1933. I have the reference, I believe accurately, in my memorandum.

According to these authors, therefore, the incidence is highest in high-income groups and not the lowest.

We may also note from these authors that 47 percent—that is almost half of our entire population—goes through the year without any illness which they reported.

Therefore, the 40 percent without medical care, from this report, is less than the number of people who claim they had no illness for the year.

I think that is a very relevant point where it is said that so many people went without care in any one year.

Senator DONNELL. Would you say that again? I want to get that point.

Dr. FRIEDMAN. According to these authors, 47 percent—practically half the entire population—reported for the year under survey they had had no illness.

Senator DONNELL. Yes.

Dr. FRIEDMAN. If half the population reports they have had no illness, it is not surprising that 40 percent would report that they were without medical care for that year. That is the point.

Senator DONNELL. In other words, a larger percentage had no illness than were without medical care.

Dr. FRIEDMAN. Some people presumably had some medical care; it may not be the same people; we cannot be sure of that, but at least the people without medical care were less than the number of those who reported no illness.

There is a very definite relationship.

You may wonder why. Even in Dr. Falk's data the incidence of illness should be higher in the high-income groups. This is one very important point which has been completely lost sight of in all these discussions. As a man works honestly and industriously, his earning capacity increases with the passage of the years. In the population surveyed by Falk and his coworkers, the higher income groups contained many more older people than the lower income groups. Indeed, in the highest income group, persons over 45 years of age were twice as numerous—more than twice as numerous—as the persons over 45 years of age in the lowest income group.

When we stop to consider, apart from any minor illnesses, that the major illnesses—heart disease, cancer, the things which maim and kill, the degenerative diseases—are much more frequent in older age groups, the importance of this observation becomes strikingly apparent; that is, you would expect any group having a higher content of old people to have more serious illnesses than another group with younger population, and that is the point which I think might bear on some of Dr. Falk's statistics.

When we consider the volume of care given in 1929, as reported by the committee on the cost of medical care (table 17), I have taken the liberty of expressing these volumes, not in big numbers but in percentages, compared with the lowest income group, for these purposes of calculation, the volume of those obtained by the lowest income group is taken as 100 and the increments or decrements above or below that are expressed in percentages.

If you look at the table, you will see that there is, indeed, a progressive and steady rise of dental services as with each increment in income, so that the people earning in that year between $2,000 and $3,000 received more than twice as much again dental care as the people did who earned under $1,200 a year.

On the other hand, if you look at doctors' calls, the people earning $2,000 or $3,000 a year got only 20 percent more doctors' calls than people under $1,200 a year.

We may pause to realize here again that we must take into account the difference in population surveyed by Dr. Falk. When you look at the hospital care administered, there is no relationship whatsoever between income and volume of care administered. Indeed, the lowest income group received more hospital care in volume at least than any income group until the rate of $10,000 per year is passed.

No group up to $10,000 a year received as much hospital care as the group under $1,200 a year. These are not my figures. These are those of Dr. Falk and his associates.

When we speak of health conditions, the same thing is true up to eleven; and when we speak of immunizations, a similar kind of correlation or lack of correlation occurs.

My point is this, gentlemen, that with respect to some aspects of medical care, there is a correlation, not necessarily casual relation, but a correlation between volume of service administered and the income family when we speak of other aspects of care; there is either poor correlation or none whatever.

If all aspects of medical care were dominated by the economic aspects, if they were all affected alike by economic factors, by economic barrier, we should expect that each kind of medical care and attention would rise in parallel with increase in income.

As you may see from this income, there is no parallelism whatsoever; they vary independently. We must therefore—I would not say that there is no economic barrier, but it is perfectly obvious that if there is an economic barrier there must be other factors equal to or greater than the economic barriers; I do not see how this table could be interpreted in any other way.

We have seen statements in Senate Reprint No. 4 of the Seventy-ninth Congress, that 37 percent of all illnesses, disabling and nondisabling, reported by families with less than $1,200 income, were unattended. I think that statement carries more than any other I know the implication that we do have widespread neglect by the medical profession.

But we might ask just what are these illnesses which were unattended.

Again, I should like to quote from Dr. Falk's work. There were many definitions of illness, among them "any condition for which 50 cents or more were spent on drugs." Any condition requiring 50 cents or more for drugs was classified as illness.

Of all those illnesses of which we may talk, 47 percent were not disabling, which means in the terms defined in that monograph, did not interfere with the usual activities of school work. Eight percent were disabling in that sense, but the patients remained ambulatory, that is, they were up and around.

In other words, 50 percent of all these illnesses which were reported were of such nature as to permit the patient to be up and around and almost half did not interfere with usual activities.

When you look at the kinds of medical affliction constituting these illnesses, 40 percent were of the minor respiratory tract or were minor gastrointestinal upsets. These things are the kinds of illnesses which most people do not bother doctors with. Maybe they should, some of them, but the average person with a cold does not run to the doctor the first thing with that cold; so that when you look at these illnesses and you see 50 percent or almost 50 percent are of a minor nature, 50 percent did not confine the patient to bed—they are up and around—it is not unexpected that 37 percent were unattended.

Maybe some of that 37 percent should have been attended. We cannot answer that from the data available, but there were no serious illnesses without medical attention. I think that is a very important point.

Our country has limited national resources although we have been generously blessed with most of them; we cannot afford to direct our energy to every minor problem that faces us. There are some major problems that face us.

Senator DONNELL. May I interrupt you to ask you who was it that prepared, if you know, that statement which you have quoted—37 percent of all illnesses, disabling and nondisabling, reported by families with less than $1,200 income?

Dr. FRIEDMAN. That is Senate Reprint No. 4, Seventy-ninth Congress, prepared by the Bureau of Research and Statistics, Social Security Board, under the direction of Dr. Falk, March 1946.

There remain major problems facing us which dwarf all respiratory afflictions and illnesses of that kind. These problems are concerned with those diseases which kill, namely, heart disease, cancer, nephritis, vascular disease, tuberculosis, and those diseases which cause prolonged disabilities or which maim: mental difficulties, tuberculosis, vascular disease, and others. You may note that these diseases are very much the same in both groups.

To the extent that infection plays a role in some of these diseases—pneumonia, tuberculosis, and to some extent heart disease, which I will elaborate on in a moment, housing, density of population, state of nutrition, recreational facilities and that type of thing, are of very great importance. Also of great importance are personal and public hygiene.

Senator DONNELL. Those conditions are such as would not be cured by a compulsory insurance plan?

Dr. FRIEDMAN. Those we have no cures for, by and large. But the medical profession cannot jump in; we do not have that in our power.

I should like to call your attention to the importance of heart disease. Instead of focusing on lesser important things, which is one of these I discussed a moment ago, heart disease is the leading cause of death in this country. It is among the leading causes for prolonged disability.

Twenty to 40 percent, depending upon the particular geographic area studied, is due to rheumatic fever. We do not know the cause of rheumatic fever, but it is definitely associated with infections of one kind which I need not go into here.

Senator SMITH. Doctor, let me interrupt you here. When you speak of death from heart disease, do you include the natural wearing out of the heart as a person gets old? You mean if a person dies at 96 that is death from heart disease? Or is that just wearing out of the animal? I am just wondering, when we say most of our deaths are from heart disease; we should include those that are just ordinary, common old-age.

Dr. FRIEDMAN. In order to answer your question intelligently, one would have to separate those kinds of heart disease which are degenerative and which may be looked upon, perhaps not as inevitable but as the consequence of old age. We have another form of heart disease because of that factor which you so intelligently brought up, namely, those which are associated with infection.

Senator SMITH. That is what I want to get at—the distinction.

Dr. FRIEDMAN. That is right, a very important distinction. We cannot do much for degenerative ones at present. We might be able to do something more from the infection standpoint.

Now, 20 to 40 percent of all heart disease is due to rheumatic fever. Those are approximate figures. It has been estimated that 1 percent of all of our children have rheumatic heart disease. It is an enormous problem. Medical care alone is not going to be of much value. It will enable those people afflicted already to lead more nearly normal lives, but no amount of medical care can prevent rheumatic heart disease from appearing; at least we do not know how at the moment.

There is another disease, mental disease, which is listed by the national health survey as the leading cause for prolonged disability.

I should like to call the committee's attention to some work by Dr. Hyde, published in the New England Medical Journal. This work was written for medical scholars; it was not intended to be a part of any controversy, public or otherwise. Dr. Hyde lists the factors which have contributed to the mental diseases among the draft registrants in the Boston area. In his listing of those factors, he has focused on the desirability of the community in which the people live; under the desirability he has the comment listed, medical care as one factor, educational facilities as another, the density of housing as another; social class as another—which needs more definition—the recreational facilities as another and public works and welfare, as another.

When he speaks of grade of community, he refers to all of those factors and not only to medical care.

He has graded the communities on the basis of A to F and tried to separate those factors which contribute toward mental disease.

As a matter of fact, he also included tuberculosis. I have made a very rough chart, not adequate for your purposes, but I have it for those who wish to examine it.

For tuberculosis the community grade was a very definite factor for including medical care. However, the density of population appeared to be much more important with respect to tuberculosis than the grade of community.

When we speak of mental deficiencies and the other mental diseases, the factors which are chiefly responsible for one disease or the other are not the same; they vary with the type of mental disease.

For example, in mental deficiency, community grade was the most important factor along with the ethnic group or race of the individual encountered; population density, in contrast, had no effect.

Under alcoholism, for example, the community grade had no effect. On the other hand, density of population was the important factor, along with race.

Under psychoneurosis, which is a large segment of our mental disease, community grade is of great importance; population density had very little force, and ethnic group and race are of great importance.

I am not asking the committee to consider in detail the causes for mental disease; I merely wish to point out the reason for the existence of a diseased state, that it is not due to the presence or absence of medical care.

I think we should reexamine the role of the physician in our community. We could expand our medical facilities to infinity without influencing significantly——

Senator Donnell. Pardon me for interrupting you; but do you have the reference to the New England Medical Journal in your statement? Would you put it in the record at this time? It is not in your mimeographed document?

Dr. Friedman. No, sir; it is not in there.

There are four papers to which I should refer. The first one is by Hyde and Zack, called Social-Economic Aspects of Disease, with particular reference to tuberculosis, New England Medical Journal, volume 229, page 811, 1943.

The next paper is by Hyde and Kingsley, same journal, volume 231, page 541, 1947. That has to do with mental disorders and population density.

Another paper, Hyde and Kingsley, Relation of Mental Disorders to Population, same journal, volume 231, page 571, 1944.

Another paper by Hyde and Chisolm, Mental Disorders in Relation to Race and Nationality. New England Medical Journel, volume 231, page 612, 1944.

In concluding on the role of the physician, I think it is only fair to state that we could expand our medical facilities to infinity with our present limitations of knowledge without affecting the frequency with which we find, the incidence, rather, of many of these leading causes of death or disability.

The physicians are not responsible for our present housing conditions. Nor are they responsible for the inadequate educational facilities which limit our efforts. Neither by the administration of pills from a little bottle or by universal inoculations, X-ray therapy, or use of radioactive elements, or any other gadgets, can your physicians quickly, cheaply, and effectively erase the consequences of illiteracy, overcrowding, undernutrition, inadequate plumbing, and a widespread neglect of public and personal hygiene.

The medical profession alone cannot shield the entire population from the effects of economic maladjustments.

That is all, gentlemen.

Senator SMITH. Doctor, I am very much impressed with your testimoney because it brings a little different approach to this question, the implication of what you say.

As I sum it up, first there has been overstatement of the defective health of our entire population based largely on the reports of the Selective Service.

Dr. FRIEDMAN. Yes, sir.

Senator SMITH. You have endeavored to show by your figures that even though we had a complete, over-all, Wagner-Murray Dingell coverage, you would not have met a good many of those cases incapable of being cured, by so-called over-all medical care.

Dr. FRIEDMAN. Yes, sir.

Senator SMITH. Another point that interests me particularly is that in your break-down it is not apparent, from studies you have made and from some of Dr. Falk's figures, that we have neglected the low-income group as much as has been stated by some of the witnesses.

Dr. FRIEDMAN. I think that is correct.

Senator SMITH. And that we are not in desperate need of a tax of two to three billion dollars in the United States in order to see that everybody gets adequate coverage, assuming you could get adequate coverage by such a tax; am I correct?

Dr. FRIEDMAN. That is my point; yes, sir.

Senator SMITH. And it is a little different approach. I will admit myself that one of my purposes in introducing the bill, S. 545, with Senators Taft, Donnell, and Ball was to try to find some way by which we could help take care of those people who are unable economically to take care of themselves. I do not like to talk in terms of the means test. Many talk as though that were something terrible. In the last analysis, society has the obligation to take care of those who are economically unfortunate, and I see no disgrace in having a plan that does try to take care of indigent or medically indigent people. I still feel that if we can have those who can afford to pay for medical service do so, there will be a healthier society than through trying to socialize the whole picture.

Dr. FRIEDMAN. I heartly agree with that.

Senator SMITH. I would not even used the word "socialize." That seems to be a "red rag" to some people. I am simply discussing the program that compulsory plans take care of everybody without any responsibility on the individual for himself or his family and which calls on those who enter the medical profession to be part of a national scheme.

I have great doubt as to the incentive to young people to go into medicine if they are going to be regimented in a plan where they are going to be taken care of by over-all tax rates rather than by the use of the usual incentive of taking off the coat and going to work and proving worth by competitive methods. We are getting into fundamental things in the philosophy of government and I personally want to express to you appreciation for giving us this other aspect as we may have gone too far in thinking we have a desperate situation which must be cured overnight.

Dr. FRIEDMAN. I think we have gone too far.

Senator SMITH. I think that leads me to my next thought, which is basic to the whole philosophy of S. 545; it is a trial-and-error method. We have 48 States and I trust the medical profession and I trust the State governments; I trust our State boards of health to be just as much concerned about this thing in their respective jurisdictions as the Federal Government, and they have the immediate responsibility—I want to use this slang expression—to pass the buck to each State. You have this problem, whatever it may be, whether greater or less. My own State of New Jersey has it. I do not want any responsibility taken off my own State of New Jersey to meet that problem.

I do not want to say, "You can forget it because we are going to have an over-all Federal plan here and you are going to be taken care of in New Jersey." I want New Jersey to do the job and I do not represent my people properly if I do not challenge them to meet that test.

That is the way my mind is moving on this and I have helped to carry out some of the thoughts I have by pointing out that we are not in the desperate need as built up by a lot of propaganda and publicity to make us feel that we are a Nation, half of us unhealthy and half of us without medical assistance.

Dr. FRIEDMAN. There is an even more important point to your remarks, Senator, when you regard specific problems. For example, despite the Negro worker in the rural South having a lower economic status in many instances, with respect to one disease, rheumatic heart disease, his geography works for him. In other words, the problem of caring for those people is different; the incidence of rheumatic heart disease in the southern Negro purely because of the geography is much less of a problem than of a well-paid worker living in the crowded industrial North.

As you proceed down the Atlantic coast line, rheumatic fever progressively decreases and in New Orleans it is of very low incidence.

If you focus some of these major diseases, geography alone, irrespective of economic status, has an important bearing so that the problem, the big problem, the chief problem is not the same in each one of our 48 States. You could amplify that ad infinitum.

Senator SMITH. Then you agree with the principle of the trial and error method and not going too rapidly in moving toward the health program of the country but doing it on a decentralized basis.

Dr. FRIEDMAN. As a scientist, I agree. All scientists agree with the trial and error method. We sometimes prove our own ideas are wrong by trial and error.

Senator SMITH. You do not think we are called upon yet to change the whole social approach to this question?

Dr. FRIEDMAN. I think the dangers inherent in it are too great and the situation not sufficiently urgent to make that approach. I personally feel that however serious disease is, it is not the only thing, that our individual liberties and freedoms are more important than the presence or absence of some disease.

I would be very reluctant to surrender the freedom we have in this country merely to cure some disease, however important that seemed to be at the moment.

Senator SMITH. And I imagine you would agree that comparing our country with other countries on the question of practice in medicine and health and all those figures, that we would stack up pretty well.

Dr. FRIEDMAN. I have no first-hand knowledge of that. I am not competent to answer. I may tell you, if I may interject a quotation from a colleague who was a professor of medicine at Berlin before the Hitler regime, who was forced to come to this country and take his State board examinations. This man, whose name is Ernest Mosely, is still available for testimony if you desire him. He had as one of his responsibilities in Berlin the framing of examinations for applicants for medical licensure in Germany or that area of Germany. He has become somewhat unpopular with fellow refugees because he was perfectly frank in his opinion that the average medical graduate in the United States is much better prepared technically than many of the professors he knew in Germany.

He found it most difficult to prepare for the type of examination which our ordinary medical student would be expected to have in this country. According to him, the difference is tremendous.

I have no first-hand information about it.

Senator DONNELL. Just a few questions.

Now, Doctor, the concluding sentence of your written statement which has been incorporated in the record is as follows:

"The health of this Nation is not in such desperate state that we must rush to surrender the complete control of the medical care of our people into the hands of an all-powerful Federal agency."

That is your belief, is it not?

Dr. FRIEDMAN. That is my own personal opinion.

Senator DONNELL. And you have studied S. 1320?

Dr. FRIEDMAN. In great detail.

Senator DONNELL. Do you regard the Federal agency therein as one that is wise to commit these matters to or not wise to do so?

Dr. FRIEDMAN. I think most unwise because from any administrative problems, as the Senators have already ably brought out, the boards which are appointed in this bill are predominantly lay people and for one thing, the act specifically states that these boards, particularly the advisory boards, shall pass on professional standards and services which are to be administered. I cannot understand a layman presuming to know a sufficient amount about medicine to pass on the standards of specialization—who is to be a specialist, who is not to be a specialist, what are the standards of service. That is precisely stated in the bill.

That would be my point of objection.

Senator DONNELL. How do you regard the provision of the bill which provides that all functions of the national board are to be under the direction and supervision of a man who is not required by law to be a doctor and at the present time is not a doctor?

Dr. FRIEDMAN. Regardless of whether or not he is a doctor, that sounds like tyranny to me.

Senator DONNELL. Doctor, referring to conditions elsewhere, where sickness and health insurance, insurance of a compulsory nature has been tried, I introduced into the record this morning a statement from the book of J. G. Crownhart, secretary, State Medical Society of Wisconsin; copyright 1938. I will ask you to state whether you are familiar with that book.

Dr. FRIEDMAN. I have read parts of it, but the entire book, no; I have not read the entire monograph.

Senator DONNELL. I notice you have used it as one of your references for some particular matter in your paper. I shall ask you to state whether or not you know the standing of this book.

Dr. FRIEDMAN. No, sir; I do not. I am not competent to judge on that.

Senator DONNELL. Now, I observe also in the course of your written statement that you refer to an experience in Rhode Island. There was compulsory insurance there which did not go to the extent of actually providing the medical services but provided for a species of reimbursement of expenses; that is right, is it not?

Dr. FRIEDMAN. That is still in operation, I believe.

Senator DONNELL. And yet, even though that did not go to the point, to the extent of having doctors themselves selected by governmental authorities, or under the direction of governmental authorities, as I assume, although I have not read the Rhode Island statute, I find that you state this, and I will ask you to say whether or not this is in your judgment well verified—this is from your statement:

"After a year's operation of compulsory insurance in Rhode Island all participants"—and you quote there a Victor Johnson—"all participants are reported to have agreed that administrative costs were higher than expected; red tape was excessive and interfered with the quality of medical care, and there was need for a decentralization program." And you state in conclusion that if this proves to be true in a tiny State like Rhode Island, what are we to expect with a huge operation that would attempt to cover the entire country—that does represent your well-considered view?

Dr. FRIEDMAN. Yes, sir.

I may point out that I have not studied personally the plan in Rhode Island. I know of it only by reports which I have cited.

Senator DONNELL. Do you know one A. M. Simons, author of the Way of Health Insurance, formerly a member of the staff of the American Medical Association?

Dr. FRIEDMAN. No, sir.

Senator DONNELL. I offer into the record at this time a clipping from the Christian Science Monitor of March 31, 1945, wherein there are set forth some comments of Mr. Simons, the opening sentence of which reads:

> Compulsory sickness insurance does not improve the health of the community as indicated in the records of foreign countries, but on the contrary the paternal-

istic governmental system of general medical care tends to encourage illness and results in a rising rate of recorded sickness and demand for medical service.

I ask you also whether you have ever heard of Douglas Robb, who writes with respect to compulsory insurance in New Zealand.

Dr. FRIEDMAN. No, sir; I am not personally familiar with him.

Senator DONNELL. I offer into the record at this time an article appearing in Christian Science Monitor of June 10, 1947, the opening sentence of which reads:

> Compulsory health and hospital insurance in New Zealand has proved "inefficient, wasteful, and altogether unworthy of the people and the country," according to Dr. Douglas Robb, eminent surgeon and medical counsellor.

Therafter follow various comments from a 103-page booklet written by Dr. Robb, entitled "Health Reform in New Zealand." The article in the Christian Science Monitor of the last mentioned, dated under a location line of Auckland, New Zealand, is headed "Compulsory health insurance held wasteful, inefficient in New Zealand by surgeon."

Thank you very much, Doctor.

(The two newspaper clippings referred to above are as follows:)

[From the Christian Science Monitor, Boston, Mass., June 10, 1947]

COMPULSORY HEALTH INSURANCE HELD WASTEFUL, INEFFICIENT, IN NEW ZEALAND BY SURGEON

AUCKLAND, NEW ZEALAND. Compulsory health and hospital insurance in New Zealand has proved "inefficient, wasteful, and altogether unworthy of the people and the country," according to Dr. Douglas Robb, eminent surgeon and medical counsellor.

To aid in correcting draw-backs in the system, Dr. Robb has written a 103-page booklet entitled "Health Reform in New Zealand." He does not in any sense cirticize the project of a universal free health service based on a special social-security tax, but applauds it. His objections are directed at mishandling of the legislation, and he strongly calls for the setting up of a health services commission to inquire into all aspects of the subject with a view to workable plans for the future.

The impetus of the law passed in 1938, he declares, was a political one, and the conception of the details of the medical service also was almost 100-percent political, few medical men appearing to have been consulted as such.

Dr. Robb's comments on the operation of the social organization of health services include:

DOCTORS PROSPEROUS

"The doctors have rapidly become extraordinarly prosperous. It is comparatively easy to work up a good income almost anywhere, except perhaps in rural districts where a lot of traveling is necessary. Actual figures of doctors' incomes are not published, but some which are almost fantastic are commonly mentioned in Parliament.

"From the Government point of view, the serious draw-back in the unlimited liability. The fund has to be a bottomless pit.

"The chief, and perhaps the only advantage to the public is that they have the right to call on medical attention as and when required, the cost being wholly, or at worst mostly, met by the social-security fund. Wartime difficulties in 'first catching your doctor' are now less marked, but in spite of a nearly 50-percent increase in medical personnel since the war, it is still difficult to secure prompt and continuous attention.

"From the doctor's point of view perhaps it is a good thing that by ordinary effort he can secure very adequate rewards. Many doctors approve of the arrangements for this reason, and because they disturb former methods of practice very little. Yet all are aware of certain serious difficulties. The emphasis is placed (fee per service) on the number of acts done rather than on quality.

QUALITY OF SERVICE DROPS

"Indeed, we find the doctor personally doing a number of trifling things in his practice that ought to be done by a nurse or secretary but are not so done because it it worth 7 shililngs 6 pence each time to the doctor, if he does them.

"The quality of service rendered under general practice suffers under the fee-per-service structure, with its emphasis on quantity rather than quality. The tendency inevitably is toward quick superficial work, and the avoidance of difficult subjects, times, and places.

"The patient in genuine need of help at night or during a holiday is too often at a serious disadvantage. The hospitals become the repository of many duties that should be done by the practitioner. They cannot refuse to do them, but they are often poorly equipped in many ways to do so.

"Perhaps the worst feature of the present arrangements for general practice lies in their assumption that the style and scope of medical practice as we knew it before 1940 was good and left nothing to be desired. Only make it universally available and all will be well.

"The truth is that many medical leaders had become more than doubtful of this proposition, and were trying to wean both people and doctors away from their addiction to the old style and methods with their inevitable bottle of medicine. Far from helping this endeavor, the Social Security Act has confirmed the old method and entrenched their already vested interests with richer rewards than ever.

HOSPITAL SERVICE LAGS

"The demoralization of the profession has proceeded steadily, and it is becoming harder to find a way out."

Elsewhere in his analysis, Dr. Robb noted that, particularly in some of the large cities, the public hospitals have lagged far behind modern standards and are avoided by a proportion of the people. In some instances there is an absence of the best medical talent in the town from the hospital staff, and the public is well aware of this.

The total cost of pharmaceutical benefits has risen steadily, and now reaches almost fantastic proportions, he declared.

A notorious omission in the arrangements for general practice was all thought of postgraduate teaching and training, he added.

"One feels that the present arrangements, comfortable as they may seem, cannot last," he observed. "Not indefinitely can a system of rewards be justified. in which a doctor, newly qualified, can earn double or even treble the salary of a professor of medicine, or four times that paid to a professor of mathematics, or literature, or chemistry."

As far as the social security benefits relating to general practice go—medical, maternity, pharmaceutical—it seems as if a thoroughgoing reconsideration and revision of all aspects is now due, Dr. Robb said.

[From the Christian Science Monitor, March 31, 1945]

SICKNESS INSURANCE RECORDS INDICATE ILLNESS ENCOURAGED

NEW YORK, March 31.—Compulsory sickness insurance does not improve the health of the community as indicated in the records of foreign countries, but on the contrary the paternalistic governmental system of general medical care tends to encourage illness and results in a rising rate of recorded sickness and demand for medical service, according to A. M. Simons, joint author of The Way of Health Insurance and a former member of the staff of the American Medical Association.

Mr. Simons made this comment on current agitation for compulsory sickness insurance and cash sickness insurance, such as the new Rhode Island system.

It is not merely a case of more people going to the doctor, although that is a factor, but there are indications that of an actual increase in illnesses due to the mental effect of insurance and to the fact that under a public insurance system the medical profession finds less time to devote to preventive medicine, Mr. Simons said.

* * * * * * *

MUCH MATERIAL GATHERED

Mr. Simons, who recently retired as assistant director of the bureau of medical economics of the AMA, has made a first-hand study of sickness insurance in European countries which have long had the system, and has gathered much statistical material in the field.

"The standard system of government sickness insurance consists of both medical care and cash payments in case of sickness to make up in part for loss of wages," Mr. Simons said.

"Not only does such insurance cultivate a desire on the part of many to 'get something back' for money paid out in sickness insurance taxes, thus encouraging them to report themselves ill on the slightest pretext and sometimes when they are not sick at all, but it actually causes nervous illnesses.

"A very serious phase of the situation is that compulsory sickness insurance itself fosters a great amount of genuine sickness."

Among those whom the doctors regard as actually ill, cash payments to the sick frequently tend to lessen the desire to get well, Mr. Simons said. He quoted Dr. E. Blum, a notable psychiatrist of Bern, Switzerland, who in a detailed study of attitudes of the sick both with and without insurance, came to this conclusion relative to many individuals:

"We arrive at the tragic fact that an institution created in response to the highest social impulses * * * encourages the antisocial attitude of the sick, undermines the desire for recovery, and endangers health."

In his studies of government systems of health insurance in Germany, England, and other European countries some years before the war, Mr. Simons found a close relationship between the economic conditions of a country and the number of its insurance cases.

INFLATION EFFECTS

For example, the inflation period in Germany following World War I made cash benefits so nearly valueless that it was not worth while being "sick" to get them, he said.

German official statistics, show that the number of days of "sickness" as measured by "inability to work" fell off over 100,000,000, or 50 percent, in that period.

Fluctuations in demand for insurance as a result of economic conditions is not unusual, Mr. Simons continued. Charts in a German work on sickness insurance show a direct relationship between business depressions in Germany over a period of 23 years and the rise and fall in the morbidity rate in local German insurance societies. When business slumped, morbidity rose. He did not go so far as to say that desire to collect cash benefits was the only cause of this rise in demand. It simply indicated the close relationship between financial need and demand for cash benefits.

Even in normal times the wish to "get something back" for the taxes paid encourages the demand for medical service from a flood of patients with such minor illnesses as to have no real need of such attention, thereby depriving those who are regarded as seriously in need of medical care, Mr. Simons added. He quoted a report he wrote for the American Medical Association before the war, saying:

"Numerous German students estimate that from 60 to 75 percent of the time of insurance physicians is consumed in handling cases in which their services are of no particular value to the patient."

Excessive prescribing of drugs due to pressure from patients is another common, harmful result of government health insurance, Mr. Simons also noted.

In some cases he reported patients have demanded prescriptions so they could barter them for things they wanted.

Senator SMITH. Thank you, Doctor.

Your prepared statement will be inserted in the record at this point.

(Dr. Friedman's brief is as follows:)

STATEMENT OF MAURICE H. FRIEDMAN, PH. D., M. D., TO THE COMMITTEE ON LABOR AND PUBLIC WELFARE, UNITED STATES SENATE, EIGHTIETH CONGRESS

(Figures in parentheses in text refer to bibliography at end of statement)

Mr. Chairman and committee members, for the record my name is Maurice H. Friedman, a physician engaged in the practice of internal medicine in the District of Columbia. I represent no group or organization. For about 10 years I was a full-time member of the teaching faculty of the University of Pennsylvania Medical School, where as assistant professor of physiology my activities were concentrated on teaching and research in physiology and experimental medicine. Just prior to the recent war I was given the task of developing apparatus for the measurement of blood flow and the recording of the pulse in pilots during dive bombing. This work was done under the National Research Council Committee on Aviation, Problems of "G," in collaboration with Dr. Eugene M. Landis, formerly professor of medicine at the University of Virginia and now professor of physiology at Harvard Medical School. For about 4 years during the war I served as internist and gastroenterologist with the AAF and most of this time was spent in these capacities at the Hunter Field Regional Hospital at Savannah, Ga.

The testimony to be given will not attempt a detailed analysis of either S. 545 or S. 1320. It will deal primarily with those data which have figured so prominently in discussions on national health insurance and will underline portions of this body of data which have not heretofore been brought to the attention of the committee.

One of the chief arguments of the proponents of national compulsory health insurance is that the medical services now available to our people are so inadequate that the need for some Nation-wide, comprehensive, and compulsory medical insurance is urgent and immediate. According to this argument the status of the health of our citizenry is so deplorable that we can no longer afford to spend more time for the acquisition of more reliable data and more experience through local and varied experimentation with voluntary health insurance.

It is my contention that a fair and critical appraisal of the data now available will reveal that the situation confronting us is not urgent and that there is no need for such immediate and heroic measures as those contained in S. 1320.

The provisions of S. 545 are not based on the assumption of a critical or urgent situation with respect to the Nation's health. This bill provides for an orderly and careful survey of existing and needed facilities in each region with the expressed objective of assuring adequate medical and dental care to those citizens who are unable to pay in full for such care. While it offers Federal aid to the States in reaching such objective it guarantees to each State the right to work out its own solution to its particular local needs and the right to evolve a system of medical care of its own choosing. As an individual I can wholeheartedly support almost all of the provisions of S. 545.

The proponents of compulsory health insurance have painted a dismal picture of the status of medical care in this country. According to the testimony they have been giving before the Senate Committee on Education and Labor, the medical care a family receives is largely dependent upon its income. Families of low-income levels are unable to secure adequate care because of the economic barrier. "One-third of the people of our country do not get any medical care" (1). "* * * There are many Americans this very minute who are suffering and dying needlessly for lack of medical care" (2). The need therefore is acute. Present-day medical service is woefully inadequate. Voluntary health insurance plans cannot possibly succeed. There is one and only one way out—and that is the adoption of compulsory national health insurance.

An examination of the original data on which most of these statements are based reveals that the impression given to the Senate committee is not a true one. The statements are fractional truths tortured from a body data sincerely, and possibly accurately, gathered. No rational person would claim that the medical service in this country is altogether satisfactory. Certainly it is not perfect. Any genuine improvement would be welcomed by all. However, for a proper evaluation of the deficiencies of medical care we sorely need a calm and judicious analysis, removed from the heat and prejudice of the political arena.

THE DRAFT REJECTION FIGURES AS A REFLECTION OF NATIONAL HEALTH

Probably no point has been stressed more by the proponents of compulsory health insurance than the country-wide rejections by the Selective Service System. "Working people are shocked, just as other people were, by the extent of physical unfitness that was revealed by the selective-service examinations" (3). "Of 16,000,000 youths examined, fully half were unfit for military service.

The nature of the defects among the rejectees suggests that half to two-thirds of the defects could have been prevented or rehabilitated with timely care" (4: p. 6).

Statements such as these were made by any number of witnesses before the Senate committee and are emphasized in the daily press. As can be seen from the following analysis of the selective-service data, the defects uncovered by the draft examinations have little significance with respect to the general health of this country. Any statement to the effect that one-half to two-hirds of such defects are preventable or remediable is utterly false.

I. SIGNIFICANCE OF SAMPLE COMING BEFORE SELECTIVE SERVICE EXAMINING BOARDS

The assumption has been made, usually tacitly, by the proponents of compulsory health insurance that the statistical sample examined by the draft boards was truly representative of the young adult male population of the United States. This is not quite true. Between December 7, 1941, and December 31, 1943, the draft boards selected about 10,000,000 men for examination, and of these about 3,600,000 were rejected; i. e., a rejection rate of about 36 percent. During this period, however, 2,700,000 men voluntarily enlisted in the armed forces (5: p. 3). If these men had gone through the selective-service examination the total number of men examined would have been 12,700,000, and the rejection rate 28.4 percent.

After the enlistment of these 2,700,000 men, 37.5 percent of the residual available manpower was deferred because of essential occupation or dependency (5). Therefore the population examined by the selective service boards was the male, adult population of the United States, minus those physically fit men who enlisted and minus the 37.5 percent of the balance who were deferred because of their particular value to war industry or to their families.

II. FACTORS GOVERNING THE REJECTION RATES

It must be remembered that the selective service boards were asked to furnish men for strenuous activity and intelligent teamwork. The needs were far different from those of peacetime requirements. "A great majority of the men selected for physical examination had been drawn from useful occupations in civil life which they had followed without apparent handicap" (6). The fact that a man was declared unfit for combat duty did not necessarily mean that he was handicapped for useful civilian life. As the conflict wore on the standards of the War Department changed, particularly with respect to literacy, syphilis, teeth, and visual acuity. Despite the progressive and unrelenting drain of our best manpower from the home front the rejection rate dropped from 52.8 percent for the period of November 1940 to November 1941, to 36 percent for the period of April 1942 to December 1943 (5; p. 9). Men who had been recorded as unfit suddenly became fiit for military service, though their physical condition remained the same.

III. ANALYSIS OF THE CAUSES FOR REJECTION

From the data furnished by the Selective Service Statistical Bulletins it is not possible to account for every defect or disease noted and to assign it to a proper category. This is largely because the data furnished are not in sufficient detail. If one subtracts from the total those diseases and conditions about which there is some uncertainty, the remainder can be classified with a minimum of error. This has been done in the following discussion and tables. The data has been obtained from the statistical bulletins of the Selective Service System. Most of the discussion deals with the periods from April 1942 to March 1943 and April 1943 to December 1943, hereafter referred to as periods A and B, respectively.

A. Category 1—Conditions beyond the province of the medical profession

A little over 20 percent of all rejections were for conditions not properly in the province of the medical profession (table 1). No justification is needed for the inclusion of "nonmedical" illiteracy and mental deficiency in this group. The inclusion of venereal disease, however, will startle the average reader and should be explained.

TABLE 1.—*Conditions beyond the province of the medical profession*

The estimates were made by taking the data on principal causes for rejection, given in tables 3 and 4 of appendix C, pp. 118 and 119, (reference 5), and computing the rejection for each particular condition from its representation under the principal cause as given in table 5, appendix C, pp. 120-123. (The above computation also applies to tables 2 to 5, inclusive.)

Condition	Percent of total rejected	
	Period A	Period B
Nonmedical	0.70	3.30
Syphilis	9.40	3.70
Illiteracy and mental deficiency	10.70	14.20
Gonorrhea	.90	.30
Total	21.70	21.50

To be sure there are specific remedies, which by and large will cure either syphilis or gonorrhea if treatment is started early in the disease. However, the provision of adequate medical service, completely free of charge will not prevent these diseases, nor will such provision significantly lower the incidence of these diseases among our people. This was amply demonstrated by the experience of the Army and Navy in this recent war. The armed services had more physicians per 1,000 population than any civilian community. The services were not only available absolutely free of charge, but were urged upon the men. Vigorous campaigns against these conditions were conducted by the medical department and the venereal disease control officers. Men who voluntarily disclosed such infections to the medical officers suffered no loss of pay and no punishment in contrast with conditions in the First World War. Despite all of this, venereal disease was rampant in every establishment of the armed forces. In the Army and Navy, just as in civilian life the problem of venereal disease was particularly a problem of the colored population. The venereal disease rate among white troops was of an entirely different magnitude.

It is clear therefore that a high incidence of venereal disease is no reflection on the adequacy of medical facilities. Nor is it a reflection on the cost of medical care. The problem is really not a medical problem.

B. Category 2—not preventable—not remediable

Included in this group are conditions which are not preventable and not remediable by the means available to the medical profession today. Examples of such conditions are amputations, residuals of previous injuries, and absence of a testicle. It is not possible to restore an arm lost by amputation or to make complete restitution for the residuals of previous injuries.

TABLE 2.—*Category 2—Conditions not preventable and not remediable by means available to medical profession now*

Condition	Percent of total rejected	
	Period A	Period B
Mental disease	12.50	17.00
Defective vision	3.32	2.94
Sinusitis	.30	.33
Vasomotor rhinitis	.21	.34
Nasal deformities	.41	.20
Asthma	1.33	1.30
Cardio-vascular, including: Rheumatic heart disease; valvular heart disease; cardiac enlargement; hypertension, etc	8.30	7.00
Neurological, including: Chronic encephalitic syndrome; epilepsy; post-traumatic-cerebral syndrome	4.10	4.02
Musculo-skeletal:		
Amputation, ankylosis, arthritis, atrophy, residuals of injury, congenital defects	6.87	8.46
Nephritis	.32	.29
Peptic ulcer	1.10	1.20
Absence of testicle	.05	.06
Pes-planus	1.10	2.60
Endocrine disorders	1.30	1.00
Underweight or overweight, etc	2.32	2.10

The acute attack of asthma can be treated and the patient given relief. But the attacks will come again. The patient is not cured of asthma. We cannot prevent the onset of diabetes. Insulin will control it. With careful management the diabetic can be carried through a nearly normal life span. But we cannot cure diabetes.

Similarly, the appearance of the other conditions in this category cannot be prevented (e. g., congenital heart defects, high blood pressure, rheumatic heart disease, etc.). Once such condition has made its appearance the person involved will certainly need medical care, but medical care will not erase the abnormality. No amount of medical care could have prevented the rejections from these causes.

It is quite likely that the number of rejections in this category has been understated. For example, some spinal malformations undoubtedly belong here. Yet, insofar as some spinal malformations are due to tuberculosis, and since some of the deformities due to tuberculosis of bone might have been prevented, all spinal malformations were placed in category 6 (undetermined). In other instances, where there was some possibility of prevention or correction of the abnormality, the item was excluded from category 2 and placed elsewhere.

In any event, as may be seen from table 2, rejections for causes in this category accounted for 43.26 percent and 49.74 percent of the total rejections for the periods A and B respectively. These, together with the rejections for causes in category 1 account for about two-thirds of all rejections in both periods.

Category 3—Possibly preventable

The only disease in this category is tuberculosis, which accounted for 3.7 percent of the rejections in period A and 3 percent in period B. The medical profession has no specific remedy for this disease. With early diagnosis, enforced rest, and good nursing care, the progress of the disease can be halted in the individual patient. But the armed services would not accept a person with "arrested" tuberculosis. Indeed, about one-third of the rejections for pulmonary tuberculosis were for "arrested" tuberculosis.

The greatest promise of control of this disease is through a vigorous plan of education to facilitate a careful investigation of all contacts with clinically active cases. Eventually the incidence of clinically significant tuberculosis might be reduced materially.

Conditions in this category include enlarged tonsils, hemorrhoids, varicose veins, kidney stone, undescended testicle, varicocele, neoplasms (tumors) and hernias of all kinds. None of these conditions is preventable, but insofar as they are correctable they need not have been present at the time of the physical examination.

TABLE 3.—*Category 4—Not preventable, but correctable*

Condition	Percent of total rejected	
	Period A	Period B
Tonsils and other throat conditions	0.10	0.10
Hemorrhoids and other rectal	.50	.50
Varicose veins	1.30	1.10
Hernia—all kinds	7.80	6.30
Kidney stone	.38	.31
Undescended testicle	.60	.63
Varicocele	.11	.22
Nasal obstruction	.05	.20
Neoplasm	.60	.80
	11.44	10.16

In many cases the abnormality, though sufficient to cause rejection, might easily be compatible with the ordinary demands of civilian life and be of such nature as to cause no discomfort. Many cases of varicocele are of this type. Of the rejections for neoplasm, one-half were for pilonidal cysts, a congenital development defect of the skin at the base of the spine. Army experience with surgery for pilonida cysts was not gratifying. Many cases were worse after surgery than they were before. Toward the end of the war only simple incision and drainage were recommended for those cysts which had become troublesome.

Surgeons became increasingly wary of more thoroughgoing, or corrective, surgery. Similarly, surgical treatment would not be recommended for every individual with hernia or hemorrhoids. More than occasionally the sober opinion of the surgeon would be against intervention.

As a consequence the inclusion of all of these defects in this category overstates the number of cases which could have been rectified by treatment. Even so, rejections in this category amounted to only 11.44 percent for period A and 10.16 percent for period B.

TABLE 4.—*Category 5—Preventable and/or correctable*

Condition	Percent of total rejected	
	Period A	Period B
Deafness	0.29	0.16
Defective hearing	.35	.28
Otitis media	3.16	2.90
Teeth	2.10	1.40
	5.90	4.74

Category 5—Preventable and/or correctable

Here again the tables accompanying this memorandum include a greater number of cases than would be justified by a careful scrutiny of each individual case. For example, all cases of otitis media are included. At the present time, the medical profession has, in the sulfa drugs and penicillin the means for aborting a great percentage of all cases of acute otitis media. With our present means of treatment most cases of acute otitis media need not progress to the chronic running ear and need not lead to perforated eardrums. However, even now not all cases of acute otitis can be aborted and certainly at the time many of the rejectees contracted their acute otitis the sulfa drugs and penicillin were not available. Similar considerations obtain with respect to the inclusion of all cases of deafness and defective hearing in this category. Certainly, some of them were due to injuries or accidents of some kind or other, but inasmuch as many of them were the result of infections, all cases of deafness and defective hearing are considered to be preventable.

Rejections in this category amounted to 5.90 percent of rejections from April 1942 to March 1943 and 4.74 percent from April to December 1943.

TABLE 5.—*Category 6—Undetermined*

Condition	Percent of total rejected	
	Period A	Period B
Blindness and other eye disease	4.45	3.36
Skin	.70	.80
Nonspecified disease of ears	1.20	1.40
Mouth and gums	.40	.30
Nasal deformities	.14	.20
Other lung defects	.87	.80
Infectious and parasitic	.10	------------
Heart disease, other than rheumatic fever	.50	.42
Genitalia—Miscellaneous	.64	.50
Poliomyelitis, residuals of	1.40	.98
Spinal malformations	.60	.54
Osteomyelitis, residuals of	.83	.76
Blood disease	.10	.10
Urinary—Laboratory findings only	.52	.80
Abdominal viscera (other than ulcer)	.60	.40

In each class of defects, such as "eye," "ear," etc., the statistics in the Medical Bulletin listed in addition to the specific abnormalities, such terms as "eye diseases" or "other conditions." For example under "lungs" the subheadings are:

(*a*) asthma, and (*b*) "other lung defects." It is obviously impossible to say whether such conditions are amenable to adequate medical treatment. This category accounted for 12.91 and 11.16 percent of the rejections for April 1942 to March 1943, and April to December 1943 respectively.

From the tables (1–5)and the foregoing discussion it will be seen that about two-thirds of the rejections (sums of categories 1 and 2) were for causes which are beyond the powers of the medical profession to prevent or correct, regardless of the amount of medical service available and regardless of the cost of medical care. For 10 to 12 percent of the rejections the information furnished by the Selective Service Statistics is not sufficient to permit any reasonable and qualified person to determine their proper classification. This leaves about 20 percent of the rejections for period A and 18 percent of the rejections for period B which could have been influenced by medical care. And in order to obtain such figures we must assume that (*a*) every person with such abnormality would have sought medical attention, (*b*) that the physician in charge would have recommended corrective measures, including major surgery, in each instance, (*c*) that the patient would have accepted the recommendations, and (*d*) that the recommended procedures would have been 100-percent effective in every instance. Such assumptions are really not justified.

IV. SPECIAL CONSIDERATION OF CAUSES FOR REJECTION AMONG THE NEGROES AND FOR THE POPULATION OF THE SOUTHERN STATES

Much has been made of the fact that the rejection rates for Negroes was consistently higher than for white men, and much higher for men from the rural South than from the Northern States. The conclusion has been reached that these differentials in rejection rates were due to the lower income of the Negroes and the lack of adequate medical care, especially in the rural regions of the South. Thus, the members of the Social Security Board who prepared Senate Committee Print No. 4 concluded that these, and other similar differentials in rejection rates "leave no doubt that these rates were as high as they were because of past medical neglect." (4 : p. 6) Indeed, it would be reasonable to expect that if the cost of medical care were an important factor in the draft rejection figures, the rejection rate for Negroes would be generally higher than that for white persons. In the words of the authors of the committee on the Costs of Medical Care (7 : p. 10) "Because Negroes were generally poorer than whites it is safe to assume that on the average they receive relatively less medical service than that received by the two lowest income groups" (among the whites).

When one examines closely the details of the rejections among Negroes an entirely different picture comes to light. From March 1942 to April 1 (period A) syphilis was responsible for 30.4 percent of all rejections of Negroes, and gonorrhea for another 3.2 percent. Mental deficiency eliminated 21.2 percent and mental disease another 5.8 percent. Thus venereal disease, mental deficiency, and mental disease accounted for 60.6 percent of rejections among Negroes for this period. After April of 1943 the regulations regarding syphilis were relaxed, so that it was no longer the leading cause for rejection of Negroes. However, rejections for mental deficiency increased to such extent that the total rejections for syphilis, mental deficiency, mental disease, and "nonmedical" reasons still amounted to about 60 percent of all rejections for Negroes.

TABLE 6.—(*Data taken from Medical Statistics Bulletin No. 3, Selective Service System*). *Rejections are expressed as frequency per thousand men examined*

[Appendix D, tables 4 and 5]

	White	Negro
Mental disease	52.4	32.4
Musculo-skeletal	37.4	32.4
Cardio-vascular	33.8	42.5
Hernia	31.6	26.9
Eye	31.5	27.0
Neurological	23.1	14.6
Ear	22.4	------------
Educational deficiency	19.0	99.8
Tuberculosis	15.2	------------
Syphilis	14.9	170.5

For a better appreciation of the comparison between the Negro and white rejection rates we may profitably examine table 6 which presents the data from tables 4 and 5 of appendix D of the Selective Service Medical Statistics Bulletin No. 3 (5: pp. 133 and 134), where the rejection rates are expressed in terms of frequency per thousand men examined rather than as percentages of total rejections. Except for rejections due to cardio vascular disease, syphilis, and educational deficiency, the rate of disqualifying defects per thousand Negroes examined is significantly lower in each category. It should be noted that the cause for the higher rate for Negroes in the cardio vascular disease is almost entirely due to the greater incidence of high blood pressure—a condition for which the medical profession can do nothing in the way of prevention and very little in the way of treatment. The blanks for tuberculosis and diseases of the ear in the Negro column mean that the frequencies were so low as to exclude these conditions from the 10 leading causes for rejection.

TABLE 7.—*Incidence of defects in examined registrants, by race, April 1942–December 1943*

Defect group	Total	White	Negro
All defects	1,000.2	1,008.7	953.2
Eyes	136.1	147.9	70.7
Ears	35.1	39.3	11.5
Teeth	113.0	124.7	47.7
Mouth and gums	14.5	15.1	11.6
Nose	25.8	29.4	5.4
Throat	7.3	7.4	6.0
Lungs	15.4	16.0	12.6
Tuberculosis	19.1	19.9	14.7
Cardiovascular	51.0	49.8	57.1
Blood and blood-forming	.6	.7	.2
Hernia	50.2	52.1	40.2
Kidney and urinary	11.5	12.3	7.3
Abdominal viscera	11.0	12.2	4.0
Genitalia	33.7	34.1	32.7
Syphilis	50.2	20.8	214.7
Gonorrhea and other venereal	6.3	2.3	28.2
Skin	14.0	15.2	7.2
Hemorrhoids	11.3	11.6	9.1
Varicose veins	16.2	17.3	9.7
Educational and mental deficiency	50.7	36.8	128.2
Mental disease	67.5	70.6	50.3
Neurological	28.0	29.6	19.0
Musculoskeletal	86.1	90.8	59.6
Feet	54.6	55.0	52.5
Endocrine	8.5	9.6	2.5
Neoplasms	9.4	10.2	4.9
Infectious and parasitic	.6	.6	.5
Underweight and overweight	65.5	70.4	37.8
Other medical	7.0	7.0	7.3

A still better comparison of the white and Negro men examined from April 1942 to December 1943 is to be obtained from an examination of table 7. This table is a reproduction of table 9, page 32, of Bulletin No. 3, Selective Service System. Listed in this table is the total number of defects found per thousand registrants examined (each man might have more than one defect and not every defect found was disqualifying). Here again if one excepts educational and mental deficiency, venereal disease, and cardio-vascular disease, every recorded defect was less frequent in the Negro.

Surely these data give no support to those who would claim that the Negro, because of his lowly economic status, is receiving medical care inferior to that received by the white man. And in this connection it is well to remember that "the extremely high rejection rate among Negroes played an important role in the high total rejection rates for Southern States" (5: p. 41).

TABLE 8.—*Rejection rates per 1,000 examined (white from among 10 leading causes—April 1942–December 1943)*

	Mental disease	Eye	Hernia	Cardiovascular	Educational deficiency	Ear	TB	Syphilis
Alabama	68.2	32.3	32.2	29.4	50.5	16.9	5.6	19.8
Arkansas	49.1	33.3	31.9	46.7	63.8	18.1	17.0	18.5
Florida	60.0	32.4	50.1	36.0	29.3	16.4	11.9	35.1
Georgia	69.8	26.0	39.8	20.9	34.5	18.8	5.6	20.9
Louisiana	52.7	31.1	35.8	42.0	43.3	14.8	11.2	25.8
Mississippi	49.6	33.6	36.4	18.5	38.8	10.5	8.8	27.3
South Carolina	77.5	36.4	38.3	34.9	30.3	19.5	6.6	21.1
Connecticut	58.6	27.9	20.7	29.5	7.1	24.3	8.1	4.7
Illinois	66.8	39.2	34.2	24.9	3.2	28.0	18.3	8.4
Kansas	31.8	21.3	33.9	31.1	6.2	17.3	8.5	17.8
Michigan	73.3	31.0	33.6	32.3	6.2	26.5	12.9	11.7
New York	54.3	21.4	29.7	29.8	4.4	23.5	14.6	6.9
Pennsylvania	42.5	39.6	34.6	45.4	6.6	27.6	13.4	9.4
NEGRO								
Alabama	6.7	----------	20.5	46.1	186.6	----------	----------	151.7
Arkansas	47.6	----------	31.3	67.1	101.9	----------	----------	176.5
Florida	25.8	----------	36.3	39.5	110.1	----------	----------	273.8
Georgia	9.8	----------	27.3	47.3	157.5	----------	----------	173.5
Louisiana	40.3	----------	26.2	41.4	106.0	----------	----------	196.8
Mississippi	17.7	----------	38.1	19.8	154.8	----------	----------	235
South Carolina	42.7	----------	25.3	40.2	162.2	----------	----------	154

Still, the high incidence of syphilis and educational deficiency among the Negroes were not the only factors contributing to the high rejection rate in the Southern States. These very same two disqualifying conditions contributed heavily to the high rejection rates among the Southern white registrants. In table 8 have been tabulated those data for the more important causes of rejection of white registrants in Southern as contrasted with Northern States. Not all States are listed, but those included in the table are representative. The original data were obtained from tables 3, 4, and 5 of appendix D, Bulletin No. 3. The inclusion of all the details in these tables would in no way change the composite picture presented here. As a matter of interest, some data on the Negro registrants of the Southern States are included.

ON THE DISTRIBUTION OF MEDICAL FACILITIES

Another point raised by the proponents of compulsory health insurance is the alleged maldistribution of medical facilities. Thus Senator Pepper testified (April 2, 1946) that "40 percent of our counties with an aggregate population of 15,000,000 do not have a single recognized general hospital." "Doctor shortages are severe—in 1944, 553 counties had less than 1 active physician per 3,000 population * * * and 81 had no active doctor at all." These data, of course, are lifted bodily from the memorandum prepared for the Senate Committee on Education and Labor by statisticians under the direction of Falk (4). They may be examined in more detail in the original bulletin on page 15, where one also can learn that "an inadequate number of physicians is characteristic of rural areas." "The tendency for physicians to settle in the urban areas and in the wealthier sections of the country is particularly marked among the specialists. In 1941, 71 percent of the 1,717 certified pediatricans were located in cities with 100,000 or more population, yet 76 percent of children under 5 years of age in 1940 were in rural areas and cities of less than 100,000 population."

There is no question that the density of physicians is greater per 1,000 population in the cities than in sparsely settled districts, and there is no question that by and large specialists are to be found concentrated in our urban centers. There is no mystery about this. A general practitioner can and should care for about 85 percent of all ailments (8). This leaves only 15 percent of the ailments to be cared for by all of the specialists. Obviously, in a small community where a few general practitioners adequately care for the ordinary needs, a battery of specialists could not afford to settle in order that each of them might care for a fraction of the 15 percent of the ailments which need attention from a specialist. In order to give full-time employment to physicians who would furnish the high standards of care set by the Lee-Jones investigation, there should be about 1 practicing physician for every 1,200 people. For the full-time employment of a surgeon, however, 26,000 people are required. In the case of a dermatologist, 465,000 people are needed to furnish full-time employment (8: p. 27).

The question is not how many physicians are there in the most fortunate communities, but how many are there in the least fortunate, and what kind of medical care do people in those communities get? According to Lee and Jones (9) there were only 5 States in 1927 which had less than the 83 physicians per 100,000 population required by their standards (North Carolina, South Carolina, North Dakota, Montana, and Idaho). In the intervening 20 years profound population shifts have undoubtedly taken place. The Senate committee reprint (4) cites 4 States in 1940 as having less than this desired number of physicians (with 1 physician to each 1,784 in Mississippi, 1,684 in Alabama, 1,657 in South Dakota, and 5,565 in South Carolina).

There probably are a number of communities not adequately supplied with physicians. Such situations should be brought to light. But a tabulation of physicians per county is of little use. A county is a very artificial subdivision. A much better unit for study would be a "population center." A good example of what is meant is afforded by the distribution of population and physicians in the counties adjoining Denver, Col. Denver itself, like all large cities has many more physicians than would be required by the Lee-Jones standards. Adjoining Denver are 2 counties, Adams and Arapahoe, with populations of about 12,000 and 22,000, respectively, and with 3 and 10 physicians respectively. These counties could be, and have been cited as having an insufficient number of physicians. In Adams County all but about 500 people live in a small section within a few miles of the heart of Denver, and in this small section are found 2 of the 3 physicians in Adams County. The people of this section, therefore, have at their command not only the 2 resident physicians, but all the medical facilities of metropolitan Denver, which they use freely. Outside of this settled section are 500 people and 1 doctor. Similarly in Arapahoe County 20,000 of the 22,000 people live within a few miles of Denver. These people are served by 10 resident physicians, and by all the medical facilities of metropolitan Denver. Outside of this more heavily populated section are 2 doctors and 2,000 people (10).

By these examples of counties adjacent to Denver, we do not mean to imply that all counties recorded as having an insufficient number of physicians are not in need of additional medical facilities. But we do wish to emphasize that statistics of the kind so frequently cited in the Senate hearings are not as significant as they appear at first glance.

Of more importance to the resident of a sparsely settled area than such statistics is the accessability of medical facilities, regardless of the necessity of crossing a county line. According to Falk, Klem, and Sinai (11: p. 90) 77 percent of the population living on farms and rural communities are within reasonable access to hospitals. Still the number of persons receiving hospital care during a 12-month period was significantly less for the rural population than for the urban population. (See table 9.) This held true for all income groups.

TABLE 9.—*Percentage of persons receiving hospital care in 12 months*

[Data from appendix B24; Falk, Klem, and Sinai, reference 11]

Community size	$1,200	$1,200–$2,000	$2,000–$3,000	$3,000–$5,000	$5,000–$10,000	Over $10,000
5,000 or less	4.0	4.2	5.0	5.3	6.1	
100,000 or more	9.9	6.2	6.5	6.6	7.9	
5,000 to 100,000	8.2	5.2	6.0	6.3	8.9	

Whether this is a reflection on the medical care available or on the habits of the population was not determined. It almost certainly is not due to a lack of available hospital beds. For example, in Mississippi (9: p. 21) where the number of hospital beds available was farthest removed from the standards set up by Lee and Jones, the occupancy of those beds was only 49 percent. This situation is not peculiar to Mississippi. According to Dr. Victor Johnson (12) those States with fewest hospital beds per thousand population use those beds least and vice versa. "For example, 3 States having fewer than 2 beds per thousand population had an average bed occupancy of 62 percent; 16 States having 3 to 4 beds per thousand people occupied over 70 percent of them."

With respect to physicians' services, the situation in the rural communities is not at all clear. In every income group the percentage of illness without medical attention is greater in rural communities than in the large cities. Yet, according to the data of Falk and his coworkers, the percentage of rural persons receiving care by a physician was approximately the same as that of persons living in our largest cities (table 11). Despite the complaint about physicians concentrating in the largest cities, these data indicate that care by a physician was more frequently obtained by persons in the smaller cities (5,000 to 100,000) than by comparable persons in the largest cities (over 100,000). When we consider the question of health examinations and inoculations, the rural population appears in a still more favorable light. In every income group they obtained considerably more of these services (table 12) than did people in the large cities (though less than some income groups in the smaller cities).

As will be seen in a later part of this discussion, one must be guarded in drawing conclusions from comparisons of percentages of unattended illness. In the study by Falk and his coworkers any condition for which 50 cents, or more, was spent on drugs was listed as an illness. Was the relatively large percent of unattended illness in the rural communities due to the habit of self-medication of minor ailments? Was it due to difficulty in obtaining the services of a physician, or to inability to pay for such services? These questions are not answered by the data now available.

TABLE 10.—*Percent of persons reporting illness and receiving no care in periods of 12 months*

[From Falk, Klem, and Sinai, reference 11; appendix B 23]

Community size	$1,200	$1,200–$2,000	$2,000–$3,000	$3,000–$5,000	$5,000–$10,000	Over $10,000
Rural and under 5,000	16.0	12.8	12.0	10.4	8.7	8.3
100,000 or over	9.2	8.5	6.6	7.0	5.9	3.3

TABLE 11.—*Percent receiving care by physician*

Size of community	$1,200	$1,200–$2,000	$2,000–$3,000	$3,000–$5,000	$5,000–$10,000	Over $10,000
Rural	40.6	44.6	49.0	49.4	54.5	----------
100,000 or more	44.9	44.9	44.4	48.5	56.5	----------
5,000 to 100,000	51.7	48.7	50.6	53.0	59.6	----------

TABLE 12.—*Percentage of persons receiving health examinations and immunization in 12-month period*

[From reference 11; appendix B 24]

Size of community	$1,200	$1,200–$2,000	$2,000–$3,000	$3,000–$5,000	$5,000–$10,000	Over $10,000
Rural	9.6	10.9	13.7	11.6	16.2	----------
100,000 or more	6.3	7.8	7.1	10.0	15.1	----------
5,000 to 100,000	10.4	8.1	8.6	15.4	19.2	----------

THE ECONOMIC BARRIER TO ADEQUATE MEDICAL CARE

The proponents of compulsory health insurance have claimed that large segments of our population cannot afford to purchase adequate medical care under our present system. They deny that the services rendered gratis by the member of the medical profession are of any considerable significance. "Although low-income families have more than the average amounts of illness and greater and more frequent need for care, they receive far less medical service than the well-to-do" (4: p. 9) "* * * 37 percent of all illnesses (disabling and nondisabling) reported by families with less than $1,200 (income) had no medical attention while among families with incomes of $10,000 or more only 12 percent of the illnesses were unattended" (4: p. 10). In any 1 year "at least 40 percent of the population goes entirely without medical, dental, or eye care of any kind."

Statements such as these are easily grasped by eager supporters of compulsory health insurance. Without thought they are accepted as revealing as deplorable hiatus in the medical service of this country. They are accepted as proof of an economic barrier which stands between large numbers of our people and the medical care they need.

If 40 percent of our population were neglected, if they were denied needed medical services because of financial considerations, we should indeed feel called upon to do something drastic. But is this the case? How many of the 40 percent felt any need for medical service? How many were ill during the course of the year? Of those who were ill, how many were denied medical service because of lack of funds? To these questions there are some answers, and the answers come from the published works of Falk and his coworkers. In the 12 months of observation by the committee on the costs of medical care 47 percent of the people surveyed reported that they had had no illness (11: p. 99). Thus the number of people who went without medical care for a year (40 percent) was significantly less than the number (47 percent) who went through the year without an illness. Only 9.8 percent of the people surveyed reported some illness but received no care (11: p. 99). Was this because the "illness" was of such minor character, or was it because of lack of funds? In the following discussion an attempt has been made to evaluate fairly the kind of medical service now administered, to assess the deficiencies, and to determine how much the family income influences the medical care received.

THE INCIDENCE OF ILLNESS

Quite contrary to the statements that low-income families have more than the average amounts of illness and "greater and more frequent need for care" are the data obtained by Falk and his coworkers (11: p. 48). In table 13 are reproduced some of these data which show that the number of illnesses for each individual is lowest in the low-income groups and rises with rising income. However, illness does not strike evenly throughout the population. As noted before, almost half of the population reports no illness in the course of a year, but some individuals suffer more than once each year. When we tabulate the number of people in each income group who report no illness for a period of 12 months we see that the percentage is greater in the low-income levels than in higher income levels (table 14). Here again the data of Falk, Klem, and Sinai are contrary to the statements made in the report to the Senate Committee on Education and Labor, prepared under the direction of Falk (4).

TABLE 13.—*Average number of illnesses per individual by family income*

Family income	$1,200 or less	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000	Over $10,000
Average illnesses per individual	0.79	0.80	0.84	0.87	0.98	1.15

TABLE 14.—*Percentage of persons reporting no illness for a 12-month period, by income groups*

[Data taken from appendix 14B, reference 4]

Family income	$1,200 or under	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000	Over $10,000
Male	53.2	52.4	50.9	50.0	47.8	40.2
Female	44.1	44.9	45.3	42.7	38.1	35.1

We may well wonder why these data, on any method of tabulation, indicate a lower incidence of illness in the lower income groups. Does this mean that the poor are actually healthier than the wealthy? Personally, I doubt this, but the information collected by the committee on costs of medical care, does not permit an assessment of the "health" of the people surveyed. It is quite likely that some of the people who reported no illness for the year really had one or more minor afflictions which were forgotten. Moreover, some of those who really had no manifest illness during the period of observation were not in "perfect health." In a few would certainly be found those incipient pathological changes which would become more evident in months or years to come. Minor and early deviations of visual acuity or hearing, of blood pressure, of sensation and coordination and other such deviations from normal physical standards are certain to exist for some time before the individual becomes aware of them. Hence the data of the kind in tables 13 and 14 do not segregate the healthy and the unhealthy. They merely show the incidence of those conditions of sufficient magnitude to register in the memory of the individual. Whether or not a deviation from perfect health will be remembered by a person will depend not only upon his intelligence, temperament, and psychology, but upon his education, particularly with respect to health and hygiene. It is quite possible that the reported incidence of illness would be higher in the more prosperous groups even if the true incidence were the same (or lower) than in the lower income groups. However, this would be more likely to be true of relatively minor illnesses.

Certainly there are some illnesses which are known to be more frequent among the poor; e. g. rheumatic fever. But there is one important factor which could explain a truly higher incidence of illness in the higher income groups, and that is the age distribution of the population studied. Illness is not only more frequent, but apt to be more severe in the older age groups. In persons over 40 years of age the chronic and degenerative diseases arteriosclerosis, arteriosclerotic heart disease, hypertension, hypertensive heart disease, kidney disease, peripheral vascular disease, cancer, etc.) appear with increasing frequency so that not only is a greater percentage of this age group ill at some time during the year, but each sick person requires more medical care and longer observation than he or she required 10 or 20 years earlier. In the population surveyed by the committee on costs of medical care there were considerably more old people per hundred in the high-income brackets (11: p. 259) than in the lower income brackets (table 15).

TABLE 15.—*The population sample surveyed by the committee on the cost of medical care*

[Table from reference 11, p. 259, 38,502 persons; distribution by age and income]

Family income	Under $1,200		$1,200 to $2,000		$2,000 to $3,000		$3,000 to $5,000		$5,000 to $10,000		Over $10,000	
	Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Total, all ages	5, 871	100	13, 513	100	9, 536	100	4, 915	100	3, 409	100	1, 258	100
Age group 45–64	649	11. 0	1, 313	9. 7	1, 110	11. 6	715	14. 8	673	19. 7	319	25. 4
Over 64	247	4. 2	283	2. 1	189	2. 0	140	2. 8	106	3. 1	56	4. 5
Total over 45	896	15. 2	1, 596	11. 8	1, 299	13. 6	855	17. 6	779	22. 8	375	29. 9

Therefore, with about twice as many persons per hundred over 45 years of age in the family with over $10,000 per year income, we should not be surprised to find a higher reported incidence of illness than in the families with less than $1,200 per year income. Indeed, if no more potent factors operated to counterbalance this age factor we should expect the incidence of reported illness to rise with each rise in income, precisely like that found by Falk and his coworkers (tables 13 and 14).

The somewhat more recent statistics of the National Health Survey (1935–36) have recently become available. In this survey also the number of persons over 45 years of age is significantly greater in the higher income groups. Persons over 45 years of age comprise 30 percent of the population in families with incomes of $5,000 per year or more, but only about 20 percent of the population on relief.

At first inspection these statistics would not seem to be in complete accord with those reported earlier by Falk and his coworkers. For example, according to the National Health Survey the frequency of pneumonia in families on relief was 8.3 per thousand per year. For families not on relief, but with incomes of less than $1,000 per year the frequency was only 5.3. In the next highest income group ($1,000 to $1,500) the frequency was 4.8 and in the $3,000 to $5,000 income group 4.6 per thousand per year. Hence, if we can accept these data without question we should be obliged to conclude that pneumonia is distinctly more frequent in relief families. On the other hand, in self-supporting families there is very little difference in the frequency of this disease as one proceeds from families with $1,000 to $1,500 annual income (4.8) to families with $3,000 to $5,000 income (4.6). (See reference 32).

When we consider all types of acute illnesses there is still this sharp difference between relief and nonrelief families (33). But here also the differences in frequency of acute illnesses between income groups of the self-supporting is of a much smaller magnitude (i. e., 119 for the group with annual incomes of less than $1,000 as compared with 113 for annual incomes of $2,000 to $3,000). This is also true of chronic disease, the frequency of which is stated to be 71 per thousand per year in relief families, as compared with a frequency of 54 in self-supporting families with incomes less than $1,000 (33). However, the frequency in families of the $1,000 to $2,000 class was precisely the same as that for families with incomes of $3,000 per year or more.

How are we to resolve this apparent conflict between the data of Falk, Klem, and Sinai (11) and those of the National Health Survey? In the publications so far available the data of the National Health Survey are not given in sufficient detail to make a satisfactory analysis possible. There are, however, several points to be considered when examining the statistics of the National Health Survey. In the first place the information was gathered by untrained workers enlisted from relief rolls (Ref. 34, p. 7). These persons accepted the diagnoses of illnesses given them by the persons interviewed. These diagnoses were confirmed by physicians in only 26 percent of all illnesses, and in only 35 percent of chronic illnesses (34, p. 9). The publications of the National Health Survey do not list the data as obtained by the field workers without further manipulation. Adjustments of the data were made for age. For example, in listing the frequency of pneumonia in the $3,000 to $5,000 group, the true frequency, as actually found in the survey, was adjusted in such way as to represent a rate which would have prevailed if the age distribution in the higher income group were the same as the distribution in the families on relief (32). Adjustments were also made for those diseases with high death rates (heart disease, cancer, arteriosclerosis, etc.) to avoid "undernumeration" (35). This was done by obtaining a correction ratio from the death rate in the United States in 1935 as furnished by the Bureau of the Census.

Such adjustments in statistics are not necessarily to be viewed as a willful manipulation of data in order to arrive at a predetermined conclusion. Indeed, where many factors are operative (e. g., age, sex, income, etc.) such adjustments are necessary in order to isolate one at a time, the influence of each factor alone. Nevertheless for the purposes of this committee in particular, and for Congress as a whole, the nature and purposes of such adjustments should be fully and clearly explained. To the extent that the higher income groups contain more elderly people any adjustment for age such as that made in the National Health Survey reports would underestimate the true incidence of disease in the high-income groups and exaggerate the true incidence of disease in the low-income groups. This is especially true with respect to chronic disease. If Congress is asked to supply funds to subsidize medical services for low-income groups the estimates of the funds required should be put on the basis of the true incidence of disease, and not on what the incidence would be if the low-income groups contained as many elderly people as the higher-income groups.

When one speaks of the number of days of work lost through chronic disease one must keep in mind the fact that the nature and severity of disease is not the only factor in determining when the person involved will return to work. One other factor is the will to work. This is not the same in every person.

THE VOLUME AND DISTRIBUTION OF MEDICAL SERVICES UNDER THE PRESENT SYSTEM

If the medical care received by a family were largely dependent upon the family income, the volume of medical services received should rise steadily with rising income. Furthermore, if all kinds of medical service were equally influenced by considerations of cost, the rise in volume with rise in income should be approximately the same for all kinds of medical care. The data obtained by the committee on the costs of medical care are of direct interest in this respect (table 16). To be sure, the volume of services received by individuals in families with annual incomes exceeding $10,000 is considerably greater than the volume of services received by individuals in families with less than $1,200 per year. But there is no steady rise of volume of services with each rise in income, and the various services do not rise in parallel with rising income. This may be seen to better advantage in table 17, where the increase in volume of service is expressed as percentage of the volume received by the lowest income group. There is a steady rise in the volume of dental care with each increment of family income. At the $1,200 to $2,000 level, the volume of dental care is 50 percent greater than in the lowest income group. At the $3,000 to $5,000 level, it is almost three times as great. In contrast, the number of physicians' calls is only 5 percent greater in the $1,200 to $2,000 income group and only 56 percent greater in the $3,000 to $5,000 income group. If the difference in the volumes of services rendered depended largely on income, why should the services of dentists increase so much more rapidly than the services of physicians? The discrepancy is even greater when we regard the relation of hospital service to income. The lowest income group received more hospital service than any other except the highest income group.[1] Between these extremes there is no correlation of volume of service with income. Persons at the $3,000 to $5,000 level received less hospital service than the next two lower income groups. Similarly with health examinations and immunizations, the highest income group received more service than the lowest; but in between the relation between income and volume of service was definitely not what we would expect if cost were the determining factor. Certainly none of these major items of strictly medical care appears to be related to rising income by the same factors which correlate dental care with income. Tables 16 and 17 do not present the data on all items of medical care. For complete details, the reader may consult the original source. Suffice to say here that relation of X-ray services to income resembles that of physicians' services, while the relation of laboratory work to income more nearly parallels that of dental services.

How are we to explain this lack of correlation between income and the volume of services received under the present system of medical care? Regardless of the nature of all the factors which add up to the true answer to this question, it would seem that the proponents of S. 1320 have grossly underestimated the services donated by physicians to the low-income groups and the volume of free and low-cost hospital care. According to Falk, Rorem, and Ring (13: p. 148), free hospital care is given to 52 percent of all hospital cases occurring in families with yearly incomes of $1,200 or less. At the level of $1,200 to $2,000, 22.8 percent of hospitalized cases receive free care. And did anyone ever hear of a patient in a charity bed paying a fee to the physician for his services?

TABLE 16.—*The volume of medical services per thousand population by families with stated incomes*

[From reference 7, p. 6]

Service	Family income					
	Under $1,200	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000	Over $10,000
Doctor's calls	1,932	2,045.9	2,297	2,741	3,621	4,734
Days hospitalization	928	667	757	604	840	1,200
Immunizations	69	49	51	60	84	120
Health examinations	83	68	69	82	234	942
Dental care	118	184	247	309	446	622

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[1] It should be remembered at this point that the higher income groups contained a larger proportion of persons over 45 years of age, so that the volume of medical care needed by these groups might well exceed the volume needed by lower-income groups.

TABLE 17.—*The volume of medical services by individuals in families of stated incomes—Expressed as percent of volume of lowest income group*

[Data obtained by calculation from reference. 7, p. 6]

Service	Family income					
	Under $1,200	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000	Over $10,000
Doctor's calls	100	105	119	156	188	245
Dental care	100	155	210	260	378	525
Hospital days	100	72	82	65	90	129
Health examinations	100	82	82	100	280	1,100
Immunizations	100	71	74	87	121	175

UNATTENDED ILLNESS AND THE NATURE OF RECORDED ILLNESS

No statement carries so much of the innuendo of neglect as the kind of statement which relates the incidence of unattended illness. "* * * 37 percent of all illnesses, disabling and nondisabling, reported by families with less than $1,200 (income) were unattended" (4: p. 10). Just what are these illnesses which are unattended?

For the survey of the 9,000 white families in the study of the committee on the costs of medical care, an illness was defined as (a) any disorder which wholly or partially disables an individual for one or more days, or (b) any experience for which medical service of any kind is received, or finally (c) any condition or symptom, or disorder for which drugs costing 50 cents or more are purchased (11: p. 8). Of each thousand cases of such "illness" recorded, 554 were ambulatory. Of these, 471 were not disabling and 82 were disabling, but not bed cases (e. g., obliged the individual to refrain from work or usual activities without confining the person to bed). Of all cases of illness over 75 percent were either not confined to bed or kept in bed less than 2 days (11: p. 84).

The ordinarily observant lay person will not be surprised to learn that almost 40 percent of the recorded illnesses are accounted for by minor respiratory afflictions such as the common gold, grippe, sore throat, etc. An additional 7 percent of the illnesses are made up of common gastro-intestinal upsets (minor cases of dyspepsia, gastroenteritis, diarrhea, etc.). Thus almost 50 percent of the recorded illnesses are of a type commonly regarded as not serious by our population and for which many persons are not accustomed to consult a physician.

To be sure the percentage of persons with unattended illness was greater in the lower-income groups (table 18). The disparity between the highest and the lowest income groups is even more marked when attention is focused on the number of unattended illnesses rather than on the number of persons with unattended illness. In families with less than $1,200 per year income 33.5 out of every hundred illnesses were unattended (11: p. 281). With rises in family income the percentage of unattended illness drops to 25.0, 19.6, 18.6, 11.0, and finally to 7.3 in the families with over $10,000 per year income.

When we recall that over half of the recorded illnesses were ambulatory, and that almost half were not disabling, should we be greatly alarmed that one-third of the illnesses were unattended? Perhaps some of these cases should have received some medical attention. It is impossible to say how many. Nor is it possible to say how many cases were without medical attention because of the cost involved. Were the 7.3 percent of cases in families with more than $10,000 incomes unattended because of the cost? If not, how many out of the 18.6 percent of cases in the $3,000 to $5,000 group were without medical care because of an economic barrier? At this point let us be reminded again that the proportion of people over 45 years of age was considerably higher in the three highest income groups and that for this reason we should expect a greater frequency of more serious disease in these income groups.

TABLE 18.—*Number of persons with attended and unattended illness in percent, by income*

	Under $1,200	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000
	Percent	*Percent*	*Percent*	*Percent*	*Percent*
Illness without care	13.75	11.0	8.8	8.1	5.5
Illness with care	37.5	37.5	43.9	45.7	52.0

Probably the most pertinent body of data on the question of unattended illness is that collected by Dodd and Penrose (14). At least in this survey the interviewers asked each person if he was in need of medical or dental service at the time of the interview. If so had the need been verified by a practitioner and was treatment being received? This investigation covered 65,000 people of whom 14 percent claimed to be in need of medical care. However, in contrast to the population of the United States as a whole (as surveyed by Falk, Klem and Sinai (11) the need for care in California was greatest in the low-income groups and least in the highest income groups (being 21.9 percent at the family-income level of $0.499 and 10.3 percent at $3,000 to $4,999).

From the report of Dodd and Penrose it is possible to extract and quote such statement as "Only 56 percent of those with income less than $3,000—including almost 90 percent of the total population of the State—are receiving the care that is needed." Indeed this statement has been quoted repeatedly by the proponents of compulsory health insurance. What has not been mentioned is that 86 percent of those persons claiming the need for medical care had already seen a practitioner of their choice and had secured a diagnosis (table 19). These cases, therefore, had already received some medical care and cannot be considered as unattended. These cases by and large were attended but not all were receiving treatment at the time of the interview (table 20). When looking at the data in this table it is important to note that this survey was conducted in 1933, a year that cannot be taken as typical for the economic status of this country. Incomes were low and people were reluctant to spend what money they had.

TABLE 19.—*Percentage of persons needing care who had received a diagnosis (survey of Dodd and Penrose 14: p. 88)—Family annual income*

$0-$499	$500-$999	$1,000-$1,199	$1,200-$1,499	$1,500-$1,999	$2,000-$2,999	$3,000-$4,999	$5,000-$9,999
80.4	83.6	86.9	90.6	89.9	93.1	95.6	96.8

TABLE 20.—*Receipt of treatment by persons in need of medical care (from California survey of Dodd and Penrose, p. 91), expressed in percent for each income group*

$0-$499	$500-$999	$1,000-$1,199	$1,200-$1,499	$1,500-$1,999	$2,000-$2,999	$3,000-$4,999	$5,000-$9,999
44.1	51.5	59.9	61.0	66.1	71.2	78.7	86.1

In the families with annual incomes of $5,000 to $10,000 of 1933 dollars should we believe that 14 percent of the persons claiming the need for treatment could not afford such treatment? Are we to believe this of 30 percent of persons in families with incomes of $2,000 to $3,000 1933 dollars? When we consider that only one case out of 17 requires any hospital care, and that hospitalized cases, though only 6 percent of all illnesses, are responsible for 50 percent of the total charges for medical care (7: p. 19), do we not have the right to assume that families with $2,000 to $3,000 1933 dollars could afford some treatment for the 94 percent of illnesses which require no hospitalization?

If we can make this assumption, then we must grant that at least as many as 20 to 25 percent of persons claiming the need for medical care are going without treatment for some reasons other than cost. When one adds this 20 to 25 percent to the 44 percent of individuals in the lowest-income group who were receiving treatment, the number of persons without treatment because of cost could not exceed 30 to 35 percent, even in families with less than $500 a year income.

The validity of the above calculations cannot be guaranteed, but certainly such estimate should be considered when discussing the survey of Dodd and Penrose. For nowhere in their report is any evidence presented as to the number of persons without treatment because of an economic barrier. The authors were quite frank in recognizing this limitation of their data. In their own words—"It is important, however, to bear in mind the fact that reported ailments—reported needs for medical care—often may overexaggerate the problem. People are often to blame for the care they may need—or think they need. Especially is this true when it is claimed that 'they do not have time' or 'cannot afford to take the time' necessary to secure treatment that is genuinely needed. It has obviously been impossible to deal with these possibilities, and for this reason analysis has been made upon a basis of reported need only" (14: p. 88).

Regardless of the "reported need" for treatment and the relative importance (undetermined) of the economic barrier in the population surveyed by Dodd and Penrose, their findings cannot be applied to the people of the United States as a whole. The population of California simply is not truly representative of the population of this country. Dodd and Penrose recognized this (14: p. 21)—"Entirely aside from the question of payment for medical care certain special considerations are involved. The influx of invalids seeking climatic benefits, those seeking recovery from less serious physical and mental defects, and the presence of a disproportionate number of elderly people requiring more care than the average person are undoubtedly factors increasing the need for the facilities obtainable by the population of the State as a whole."

COSTS OF MEDICAL CARE

So far we have discussed only the incidence of illness and the distribution of medical care with respect to family income. The data presented have dealt with averages—the average number of illnesses per thousand population and the volume of services rendered per thousand people—or to the average person. No consideration has been given to the unfortunate family which, because of some very serious illness, has been obliged to shoulder a cost far beyond the average. It was apparent to the committee on the cost of medical care that "No conclusion has emerged more consistently than this: The costs of medical care are felt as a burden more because they are unevenly distributed than because of their total amount." That is the core of the very valid argument in favor of some kind of health insurance—the protection of the self-supporting individual or family against costs which the ordinarily prudent citizen cannot anticipate. Serious or catastrophic illness is just as much of an accident as a collision or a fire, and there should be available to our people the opportunity of insuring against the accident of major illness just as we can now insure against the accident of collision or fire. This would spread the costs of illness over large numbers of people and iron out those inequalities of cost which make medical care seem a burden. But to estimate the costs of such arrangement we need to know the total costs of medical care.

One estimate was made by Bradbury (8) who calculated the costs from the services needed on the basis of the Lee-Jones standards and the prevailing fees of the Chicago Medical Society. This estimate called for the expenditure of about $75 per person per year, or about $300 per year for the average family. This did not include dental services or drugs. The Lee-Jones standards outline a medical service for everyone superior to the care now being given to the individuals of our highest income groups. They provide for hospitalization of 10.6 percent of all cases (117.5 cases of the 1,111 to be expected per thousand population, and which includes 175 refractions for glasses) as compared with hospitalization rate of 5.88 percent as actually found in 1929 by the committee on costs of medical care (7: p. 19). The Lee-Jones standards also provide for some nursing service for 430 cases of the total of 1,111 per thousand persons, or 39 percent. When we consider that over half of all "illnesses" are ambulatory and that over 75 percent are either up and around or in bed for less than 2 days this seems like a very liberal use of nursing service. An inspection of the detailed analysis for each illness confirms this impression. A part-time attendant is provided for in some cases of the common cold. There is provision for a part-time attendant for 5 days in the average case of chicken pox and for a full-time attendant for 12 days in the average case of measles (9: p. 178).

These estimates are included in the total services required for good medical care. To be sure, a child with a cold, or with the average case of measles or chicken pox, is not left alone in the house without care. Some attention is necessary. But this is the kind of thing the American housewife takes in her stride. If the housewife is well, there is no need to call in a nursing attendant from the outside.

This liberality in the use of nursing service is matched by the allowance for hospitalization and for physicians' services. If physicians were paid for their services under a system as outlined by Lee-Jones and Bradbury, the average gross income of the general practitioner would be $16,920 and of the specialist $45,285 (8: p. 28).

This is considerably higher than the actual incomes in 1929 as estimated by Leven (8: p. 28), which were $6,400 and $16,300, respectively. Such incomes are also much higher than those reported in 1944 when the remaining physicians were worked to the limit (15). Lee and Jones were aware of the gap between their standards and more practical objectives. Of their own estimates they say (p. 14), these estimates "cannot be regarded as an immediate practical objective in any community, nor can they be used as a rigid and detailed standard by which to judge the adequacy or inadequacy of local medical facilities."

The most frequently quoted estimate of the cost of medical care is that made by the committee on the cost of medical care, based on actual expenditures in the year of 1929 (7). In this year the total spent for all medical services, including dental services, was about $3,660,000,000, which amounted to about $30 per capita, for $120 per family. However, this total amount includes many items for which the private person is not obliged to pay and for which he therefore does not need to be insured. This total of $3,660,000,000 includes $121,000,000 for public-health activities which are paid for by State and Federal taxes. In addition to $278,000,000 paid by patients toward the operating expenses of hospitals (in fees) this total includes $300,000,000 paid by governmental agencies, $54,000,000 paid by philanthropic foundations and $24,000,000 paid by industry for the operating expenses of hospitals. It also includes (p. 14) $200,000,000 for the new construction of hospitals. In this country over 90 percent of the funds invested in the capital plant of hospitals is furnished either by the Government or by some philanthropy, and these hospitals are operated on a nonprofit basis.

There is no need for any insurance scheme to finance those services already paid for by taxation. Nor is there any need to take over and finance those services already paid for and so well furnished by the gifts of public-spirited citizens. There is no need for such steps unless we wish to form some huge agency to take over all health services now being furnished by State and Federal Governments and to crowd out and supplant the activities of the Rockefeller Foundation, the Carnegie Foundation and innumerable other philanthropic agencies.

When calculating the total costs to be borne by a health-insurance agency, these several items, already paid for by governmental or philanthropic agencies, should be excluded. Also to be excluded are $4,770,000 for drugs purchased for self-medication. Regardless of the provision of medical service by any kind of insurance scheme, it is very doubtful that people could be prevented from paying out their money for the experimentation with self-medication. And, finally, most proponents of any kind of health insurance would exclude the item of $193,000,000 (p. 28) which was paid for services of irregular practitioners, health healers, cultists, etc.

The above-mentioned items, all together, total $1,370,000,000, which if subtracted from the total health bill of 1929, would leave $2,290,000,000 as the amount properly to be charged against the private individual. This is equivalent to $18.75 per capita for complete, all-inclusive medical and dental care, and is slightly less than the estimate made by Falk on the basis of the medical-care program at Fort Benning; i. e., $20 per capita (13: p. 152). However, this estimate of $18.75 is for the cost of services only and does not provide for the administrative expenses . Any insurance plan will add something to the cost of medical care and this added cost in overhead and administration will depend on the size and the efficiency of the organization. The administrative costs of the

Michigan Medical Service plan were initially 20 percent, but with continued growth and increasing experience this cost has been reduced to 11 percent (1944–45). The Blue Cross apportions 12.1 percent for administration, 6.3 percent for financial reserves and pays out 81.6 percent for services (16: p. 10). If we were to consider $30 per year as an appropriate annual premium for each insured person an allowance of 15 percent for administration would leave only $25.50 for medical and dental services, and nothing for reserves. In order for our people to secure a volume of medical and dental services equal to, but no greater than, that received in 1929 (per capita), this balance of $25.50 would have to purchase a volume of services which cost about $19 in 1929. At present prices this is by no means a certainty.

HOW MANY FAMILIES COULD AFFORD MEDICAL CARE AT $100 A YEAR?

Assuming that the figure of $30 per capita, or about $100 per family, is a reasonable premium, how many of our families could afford such insurance? The Assistant Secretary of Agriculture, Mr. Charles Brannan, (17) has testified that 80 percent of all farm families would be unable to afford such expenditure for health insurance. Dr. Fred Mott echoed this opinion at the National Conference for Rural Health (18) and was obviously using the same data on which to base this opinion.

These data are for 1941–42 (19) and in order to substantiate the opinions of Dr. Mott and Mr. Brannan we would have to admit that all farm families with cash incomes of $2,000 or less could not afford $30 per capita for medical service. But the cash income of a farm family is not a fair criterion to use. Income in kind may account for 30 to 66 percent of total farm income (21). Moreover, due allowance must be made for the lower level of retail prices at which the farmer buys his goods (20) and this is particularly true in the South, where about one-half of all farm families live (20). Allowance must also be made for the much lower cost of food, fuel, and housing. $1,500 a year is a much better income on a farm than in a large city.

It is impossible to define a family income which will permit the expenditure of sufficient money for medical care and a family income which will not permit such expenditure, without making some fundamental assumptions as to the relative importance of medical care. From the tenor of the testimony given by the proponents of compulsory health insurance, one gains the impression that medical care is of prime importance to our people—almost equal to the importance of food and shelter. Such high regard for medical services was not always expressed. "It might be said that a person's ability to pay for medical care is measured by the extent of his financial margin over the base cost of such food, clothing and shelter as is necessary to keep him from perishing. This is true but hardly useful. For medical care is not the most important thing in the world. The need for medical care is not only one need among many. Accordingly, the real question is: How much can people afford to spend for medical care in view of other pressing and important needs?" (Falk, Rorem and Ring, 13: p. 149). In other words, how does medical care "measure up" against automobiles, radios, motion pictures, liquor and nail polish?

A scrutiny of the spending habits of low-income farm families of Pennsylvania and Ohio discloses some facts which are not usually brought to the attention of the Senate Committee on Education and Labor. In the first place, the yearly expenditures of the lowest income group ($0 to $249) exceeded the expenditures of higher-income groups until the level $750 to $999 is reached (table 21). In commenting on this paradox, Hollingsworth and coworkers say, "In both the farm and village group at this level the majority of families had deficits during the year (1935–36); i. e., the value of their consumption exceeded their incomes. Both groups apparently included families having resources sufficient to enable them to live beyond their incomes of that specific year, but such families were more numerous, relatively, in the farm than the village group. The fact that many families at the lower extreme of the income distribution maintained a level of living beyond that permitted by their incomes, that they were not so poor as their income for the year would indicate, should be borne in mind in interpreting data concerning their expenditures for medical care as well as for other categories of family living" (22: p. 32).

Table 21.—*Expenditures of farm families for essentials—Pennsylvania and Ohio study, 1935–36*

[Reference 22, table 17]

Family income	Annual Expenditures						
	Total expenditures	Food	Housing	Household operation	Clothing	All essentials	Balance
0–$249	$927	$323	$170	$119	$91	$703	$224
$250–$499	731	311	132	80	46	589	142
$500–$749	805	365	138	88	54	645	160
$750–$999	935	419	164	92	70	745	190
$1,000–$1,249	1, 101	474	201	103	87	865	236
$1,250–$1,499	1, 260	517	224	122	103	966	294
$1,500–$1,749	1, 364	539	247	121	117	1, 024	341
$1,750–$1,999	1, 464	544	284	134	130	1, 092	372

The second point which should be noted from the examination of table 21 is that, after paying more for the essentials of life than the higher income groups, families with $0.00 to $249. annual incomes had left a balance greater than any income group until the level of $1,000—$1,249 is encountered. This balance, of course, is not a balance in the sense of savings, or excess of income. But it represents the difference between what these families spent on the essentials of life and their total expenditures for all items. It should be emphasized here, that the families included in this study were all self-supporting. None had been on relief of any kind.

Some of the optional expenditures made by these farm families are shown in table 22. For comparison, the expenditures for medical care are also listed. The amounts allotted to expenses for automobiles were calculated for family use only and do not include the necessary uses related to the operation of the farm (see p. 233, ref. 22).

If we consider medical care to be one of the necessities of life, it should compete with food, fuel, clothing, and housing in the family budget. Certainly, we have a right to expect that optional expenditures would be kept to a minimum until the necessities of life, including adequate medical care, have been provided for. As may be seen from table 22, the amount spent for medical care was less than spent by every income class for non-essential, family use of the automobile (use not connected with or chargeable to farm operation). In the lowest income group the amount spent as gifts and taxes alone, if added to the money spent for medical care would have paid the $100 premium for health insurance. In the $750 to $999 class, after allowing for the $32 actually spent on medical care, the $100 premium could have been paid by the diversion of 44 percent of the balance (about $160) of optional expenditures for items other than medical care. For the $1,000 to $1,249 class such diversion need have been only 29 percent of the balance of optional expenditures, and for the $1,250 to $1,499 class, only 21 percent. If a diversion of 30 percent of optional expenditures toward the cost of all-inclusive medical care is a reasonable expectation, then only about 30 percent of the farm families surveyed in Pennsylvania and Ohio in 1935 could be judged incapable of paying for medical insurance on the basis of $100 per family.

Although the Pennsylvania-Ohio farm families are not the most favored financially, they are not by any means the least favored. At each level of reported income the total expenditures of farm families in the Southern States was lower than that of farm families in other areas. This was particularly true of the Negro farm operators in the Southern States (tables 23 and 24). Nevertheless, the composite picture of income and expenditures of the Pennsylvania-Ohio farm families was not unique. With minor quantitative variations it may be accepted as the pattern of farm finance. The total annual consumption of goods and services is much higher than we would anticipate from the reported incomes. The expenditures for nonessential items is far in excess of what we might expect. With the exception of Negro farm operators in the South, a diversion of 30 percent or less of the 1935–36 optional expenditures toward the payment for medical car would have permitted farm families with incomes of $1,000 or more to pay a premium of $100 for health insurance (income of course is total or true income and not cash income). On this basis less than one-half of the nation's farm families could have been judged capable of paying their full share of the cost of medical care in 1935. A similar examination of the annual expenditures (table 25) of village families (22: p. 7) and the distribution of income in 1935 (20: p. 25) would lead to the conclusion that about 30 percent of these families could not have paid their full share of the costs of medical care.

TABLE 22.—*Expenditures for optional items and for medical care*

[Reference 22, table 17]

Income group	Total optional expenditures [1]	Medical care	Automobile (family use)	Tobacco	Gifts,[2] taxes, etc.	R [3]
0–$249	$224	$33	$39	$11	$71	$4
$250–$499	142	34	45	11	18	8
$500–$749	160	29	58	10	17	8
$750–$999	190	32	71	12	22	10
$1,000–$1,249	236	45	82	12	26	13
$1,250–$1,499	294	47	104	11	37	19
$1,500–$1,749	341	46	140	13	39	21
$1,750–$1,999	372	58	143	13	39	22

[1] Expenditures for medical care are included in these totals.
[2] The only taxes included under this heading are poll taxes and income taxes.
[3] This heading includes direct expenditures for entertainment and recreation.

TABLE 23.—*Essential and optional expenditures of white farm famiiles in the South, 1935–36*

[From table 35, reference 23]

Income groups	Total expenditures	Total essential [1]	Total optional	Auto (family)[2]	Medical care
Georgia and Mississippi					
0–$249	$459	$363	$96	$24	$17
$250–$499	459	389	69	15	15
$500–$749	656	544	112	29	26
$750–$999	860	680	180	53	32
North Carolina and South Carolina					
0–$249	394	322	72	8	26
$250–$499	520	406	114	20	38
$500–$749	709	579	130	40	40
$750–$999	885	687	198	56	49

[1] For definition see table 21.
[2] Exclusive of use relative to farm operation.

TABLE 24.—*Essential and optional expenditures of Negro farm familities, North and South Carolina, 1935–36*

Income groups	Total expenditures	Total essential [1]	Total optional	Auto (family) [2]	Medical care
0–$249	$289	$248	$41	$2	$11
$250–$499	441	361	80	21	18
$500–$749	624	510	114	32	23
$750–$999	806	644	162	50	37

[1] For definition, see table 21.
[2] Exclusive of use relative to farm operation.

TABLE 25.—*Expenditures of village families for essential and some optional items, including medical care*

[Reference 22, p. 7, Middle Atlantic and North Central areas]

Income	Total expenditures	Total essential	Total optional	Auto [3]	Medical care	Gifts, taxes	Tobacco
$250–$499	$433	$356	$77	$15	$17	$9	$8
$500–$749	657	496	161	40	33	14	15
$750–$999	849	639	210	50	36	29	19
$1,000–$1,249	1,033	759	274	73	47	40	23
$1,250–$1,499	1,277	865	412	148	61	47	25
$1,500–$1,749	1,420	943	477	178	70	76	29

[3] Estimated for family use only.

These estimates, however, are for the year 1935 only. The percentage of families able or unable to pay any specified premium will, of course, vary with the national income and the prevailing price levels. Is the 1935 national income of 55.7 or the 1943 income of 148 billions to be considered our standard? Shall we base our estimates on a farm income of 4.96 billions as in 1936 or a farm income of 14 billions as in 1943?

Regardless of the national income and price levels, and regardless of how we define the ability to pay, in any given year there are going to be some families which cannot pay their full share of the costs of medical care. But when we talk of aiding such families we are no longer talking about insurance, we are talking of subsidy or charity. We have already seen how unsuccessfully medical care competes in the average family budget with other optional expenditures. To what extent should we subsidize medical care for low-income families? To what extent should we relieve them of the responsibility of paying for their own medical care in order that they may feel free to devote a larger proportion of their optional expenditures to automobiles, gifts, tobacco, and liquor? This is a matter of public policy and not merely a question of public health.

To provide a satisfactory health insurance for our self-supporting families is one problem. To provide subsidized services for families not entirely self-supporting is distinctly another problem.

HEALTH INSURANCE PLANS NOW AVAILABLE

In addition to those restricted plans covering industrial workers or veterans of our armed services, there are now in operation several plans which are capable of covering our entire population. One of the most rapidly growing is the Blue Cross which now has a membership of over 25,000,000 persons. The annual premiums are $10 per person or $24 for an entire family, regardless of the number of children. Enrollment may be in groups, without any physical examination, or by the individual after a physical examination. The Blue Cross pays only for hospital services. It does not pay for the services of the physician.

The proponents of compulsory health insurance have criticized such plans as the Blue Cross because they still leave an unpredictable, and often large, item to be paid by the individual. They have, however, underestimated the importance of this type of insurance. It is true that about 30 percent of the total annual medical bill goes for the services of physicians, and that the bill for hospital services plus that for nursing add up to only 29 percent of the annual total. This reflects the large number of illnesses which are seen by the general practitioner and which do not require nursing or hospital care. When a major illness does strike a family, however, the insurance against hospital costs takes care of the largest part of the unpredictable costs. Any family which has recently paid for a hospitalized illness will recall that the charges by the physician were distinctly less than half of the total costs. In many instances the charges of the physician are only a small fraction of the total, as for example in the case of the wife of an Air Forces sergent stationed in Savannah, Ga. This woman was burned severely in the early morning hours while trying to light a fire in the kitchen stove with kerosene-soaked wood. In the excitement the sergeant forgot about the free care available at the near-by Air Forces hospital and instead sent his wife to a hospital in town. The woman was there for 4½ days during which her doctor's bill came to $20 and the hospital bill came to $236.70 as itemized below:

Ward bed and board	$20.00
Extra medicine	3.20
Dressings	7.35
Adrenal cortex	13.50
Foille (a preparation for dressing burns)	56.25
Glucose (intravenously)	14.40
Plasma	112.50
Total	236.70

In general, hospitalized cases requiring surgery involve a proportionately larger amount for the physician's services, though even here the hospital services may equal or exceed the doctor's fee. The Blue Shield, operated in conjunction with the Blue Cross insures against the charges of the surgeon and obstetrician for hospitalized cases. The premiums are the same as in the Blue Cross plan, so that for a total of $20 per person, or $48 for an entire family, insurance can now be had against not only hospital costs, but surgical and obstetrical bills as well. Eventually these plans will probably include protection against all the costs of hospitalized illness (including bills of the family doctor and medical specialists).

This type of insurance is deservedly popular. It protects the insured against the costs of catastrophic illness. For most people the only charges left to be paid out of current income are those occasioned by relatively minor afflictions and which need only a visit or two from the family doctor. There will be a few cases, however, of costly illness not covered by this type of insurance, and many instances of the abuse of hospitalization for the purpose of having the insurance fund pay for an illness which could have been treated successfully outside of the hospital. For example, an early case of mild diabetes does not require hospitalization. The diabetic metabolism can be evaluated properly on an ambulatory basis (in a large proportion of cases) and proper treatment prescribed. This type of case would not be covered by a combination of Blue Cross and Blue Shield insurance, but the costs involved in the diagnosis and treatment could be a heavy burden on the average family. There might easily be the attempt to have such cases of mild diabetes admitted to a hospital so that the individual or the family would not have to bear these costs. Such practices, if not curbed, would increase the costs of the service to those cases which really do require hospitalization.

A more comprehensive coverage would avoid such problems, and there are in operation several plans which include coverage for nonhospitalized illnesses. One notably successful prepayment plan has been in operation since 1930; that is the plan operated by the King County Medical Society of the State of Washington. The membership is now about 80,000. Enrollment is limited to employees of commercial concerns who must join as a group. For practical purposes there is no income limit. For $33 per person per year complete medical service is given (exclusive of dentistry). This does not include members of the worker's family, but they may secure hospital insurance only by the additional payment of $9 per person per year. There is complete freedom in the selection of a physician. A person may go to a general practitioner for the first visit, or if he prefers, go to a specialist whose fee to the insurance fund is over four times as much.

It is worthwhile to reflect upon some of the lessons learned in the operation of this very successful plan in Kings County (25). Contrary to the expectation of the author, the people of that community have not abused the privilege of night calls. Apparently most of the insured persons continued to go to their own family physician and they had some consideration for him. Particularly during the war years when there was an acute shortage of civilian physicians, the people were accustomed to use some restraint in their demands for medical attention. Office visits, however, were abused. There were many office calls for trivia for which the insured person ordinarily would never have consulted a physician. There were many repeated visits for minor respiratory infections and other minor ailments, visits which were unnecessary and which were not checked by some of the participating physicians. In such instances the society would be obliged to request greater vigilance on the part of the physician. Some persons would consult three or four doctors in succession for the same ailment, perhaps on the same day. They would not be satisfied with the opinion given by the first physician consulted and go on to the second, third, and fourth in the hope of getting some different opinion more nearly compatible with their own prejudice. This type of thing ran up the overhead costs tremendously.

Prior to the war, hospitalization was abused in frequency and duration. The pressing needs for hospital beds during the war corrected this situation. In the early years of operation the privilege of transfusions was badly abused. Subscribers would not cooperate in replacing blood supplied without cost from the blood bank. Consequently the practice had to be stopped and now the society does not furnish transfusions of blood or plasma to the subscribers.

For a period of several months or a year the society operates at a loss with each new group enrolled. This is because of widespread abuse of the services by people who have newly gained the right to medical services without direct cost to themselves. This is usually corrected by showing to the employer the loss incurred by the society in providing service to his employees. The employer then, in cooperation with members of the King County Society, brings this situation to the attention of his workers. It is demonstrated that the service cannot be continued at the prevailing premium unless some discretion and reasonable restraint are exercised by the participants. A series of educational talks is scheduled to teach the participants how to use the service intelligently so as to protect themselves and yet not abuse the privileges of the service. Such education usually brings about a satisfactory response from most subscribers. Yet, there frequently will be found five or six individuals in each group who continue to abuse the privileges flagrantly. The directors of the King County service then take to the employer the data showing how these few employees are increasing the costs of operation inordinately by their abuses. More often than not the employer learns from his records that these five or six employees are not up to standard as workers either. Proper pressure from the employer and from the other participants in the plan aids in correcting these abuses. From then on the plan works with satisfaction to the participants and without causing an actual loss to the society.

From the doctor's viewpoint the plan seems equally satisfactory. He secures his usual fee. There is no interference between him and his patient. There is no red tape of any kind—no special records to fill out. The billing procedure is simple. For each service rendered the doctor makes out a bill on his own forms just as he would in billing his private patients who are not participants. He merely sends the bill to the King County Medical Service Bureau for payment. (It is interesting to note at this point, that these doctors who are quite pleased with their own prepayment service are reluctant to give out-patient care to veterans with service-connected disabilities because of the red tape and paper work involved.)

The King County plan has two deficiencies. It does not give full coverage to the dependents of the employees and it does not cover the cost of transfusions or plasma infusions. In the opinion of the author, the King County plan would be still better if it contained some feature requiring each person to pay for the first one or two office or house calls. The executive secretary of the service admitted that such provision would eliminate many of the abuses under the present plan and reduce the administrative costs so that the costs of transfusions could easily be covered. He also admitted that if they were starting anew, their plan would contain some such deductible feature, but having started with a plan for complete coverage they did not feel able to change now.

REFLECTIONS ON SOME OF THE PROVISIONS OF S. 1320

From the reports of the proceedings of this committee and from the resulting discussions in our daily press, large numbers of our people have come to believe that a governmentally operated, compulsory health insurance plan would at one stroke enable every individual to secure complete medical and dental care on a prepayment basis. They have been given the impression that under such plan the quality of care would be equal to, or higher than, that now obtainable and at much lower cost. They have also been led to believe that such compulsory health insurance enterprise would not jeopardize the freedom of the patient or the physician.

It is noteworthy that S. 1320 does not guarantee to furnish, at once, complete and comprehensive care. In any one year the hospitalization, which is to be furnished on the basis of the cheapest ward bed available, may not exceed 60 days for each individual. Persons suffering from tuberculosis or mental disease would not be eligible for hospital benefits. There is no provision for the cost of drugs, except for those which are unusually expensive. The latter, together with auxiliary services (X-ray, laboratory, etc.), would be available only to the extent that the National Health Insurance Board chooses to designate by regulation. Section 202–B specifically provides that the Board may limit the medical and dental services offered if the facilities or the funds available are inadequate for full and unrestricted service. In other words, every individual, not every family, would be forced to contribute, directly or indirectly, about 4 percent of his annual earnings (up to $3,600) to an enterprise of federally controlled health insurance which does not offer a specific contract for services in return. On the contrary, the services can be limited or decreased at any time by a ruling of the administrative board without consultation with the insured persons.

It is not our purpose to weigh the wisdom of such limitations of service. But it must be apparent that if the proponents of S. 1320 were certain that the costs would be covered by the proposed levy on earnings, such restrictions would not be necessary. Inasmuch as the statistics of committee on the cost of medical care figured so prominently in the discussions on the preceding compulsory health bill (S. 1606), and since the proposed appropriations are of the same order of magnitude, it is well to recall that the estimate of $30 per capita made no provision for administrative costs. This was for services only, as rendered in 1929, and at 1929 prices. Since the proponents of S.1320 have bitterly criticized the volume of medical services rendered in 1929 as woefully inadequate, provision must be made for an increased volume of services and at present price levels. Finally, provision must be made for the increased paper work in the practitioners' offices. Unless the health insurance enterprise were conducted entirely differently from most governmental operations, we must expect a volume of paper work far in excess of that required in ordinary medical or dental practice. This extra paper work, and its attendant clerical labor, would have to be paid for by the insurance fund or the cost thereof deducted from the income of the doctors and dentists.

From the experience with governmentally operated medical care in Europe, it has been estimated (26) that one administrative employee would be required for each 100 insured persons. At an average salary of $2,000 per year the salaries of such persons alone would amount to over $3,000,000,000 annually. If the proponents of S. 1320 envisage some method of operation which would not require so large a number of administrative employees, if they have a plan of operation to assure a level of administrative costs as low or lower than that of privately operated enterprises, they should reveal those plans. At any rate an estimate of administrative personnel and administrative costs should be submitted in calculating the revenue required.

If such allowances were properly made, we might then compare the estimated costs with those incurred by voluntary plans now successfully in operation. To do this, however, we would have to avoid the very convenient confusion in bookkeeping which would result from combined health insurance for self-supporting individuals with subsidy for those who are not self-supporting.

There is no question that a compulsory health insurance plan would have at least one distinct advantage over any voluntary plan—there would, indeed, be no turn-over in subscribers. If an individual became completely dissatisfied with the service he could not resign. He would still be forced to contribute directly or indirectly, 4 percent of his annual earnings. If the administrators were not sufficiently alert and firmly determined to check those abuses which have proved costly to voluntary enterprises the costs would mount rapidly. Additional appropriations would be needed. The individual would either have to pay an increased premium or be satisfied with less service. The compulsory health administration would be immune to the threat of loss of its subscribers. No privately operated enterprise could so afford to ignore the good will of its subscribers and the burden of unnecessary items of cost. It would not survive.

FREEDOM OF PATIENTS AND QUALITY OF CARE

Every assurance has been given that each individual will have a free choice in the selection of a physician. Assuming that all physicians would participate in the plan from the start, each individual might have considerable latitude in his first choice of a family physician. If, however, at some later date his physician suddenly died, or if the patient for some reason or other desired a change, he would be obliged to get permission from the administrative officer. This officer might well decide that the first, second, and third choices for a new physician were already carrying their full quota. In this event the patient's choice would not be granted even if the doctors concerned were willing and able to take the new patient. In ordinary times (excluding the abnormal conditions prevailing during the war) the selection of a physician is a matter solely between the patient and the doctor. There is no interposition of a governmental agent who might be capable of making the appropriate decision on the spot, or who might have to write to regional or national headquarters for approval of his actions. These considerations are not mere fancy. After a years' operation of compulsory insurance in Rhode Island all participants (27) are reported to have agreed that: (1) administrative costs were higher than expected, (2) red tape was excessive and interfered with the quality of medical care, and (3) there was need for decentralization of the program. If this proves to be true in a tiny State like Rhode Island what are we to expect from a huge operation which would attempt to cover the entire country?

There is one very important consideration relative to the quality of medical services which has not yet received sufficient emphasis. In any insurance plan, either privately or governmentally operated, in which no direct payment of any kind is required, the insured person will risk losing the complete confidence of his physician. This risk was a sober reality to the men of our armed forces. The provisions of a Compulsory National Insurance Act alone would not place our civilian population in a position identical with that of our servicemen. But these provisions, together with the growing protection of workmen's compensation and unemployment insurance would greatly narrow the difference between the status of the civilian and that of the serviceman.

It is appropriate, therefore, for us to consider some of the characteristics of the medical service in the armed forces. During the war private physicians became paid employees of the Government, from whom the servicemen could obtain unlimited medical care without cost to themselves. The element of cost was not considered when X-rays, laboratory work, or further consultations were indicated. Were not the medical services in the armed forces the perfect model toward which we should now strive? The answer is "No."

The wounded and severely injured received excellent medical and nursing care, as did those with acute febrile diseases. Nowhere could better medical care have been obtained. Civilians might justly envy that kind of medical service. But what about arthritis of the spine at a stage when X-ray changes are not demonstrable? What about heart attacks in young men in whom there are not electrocardiographic changes until 10 days to 2 weeks later? What about peptic ulcers which are not demonstrable by X-ray? In such cases laboratory aids fail us. Physical signs may be absent or inconclusive. The diagnosis depends almost entirely on the history as given by the patient. But the Army or Navy doctor could not believe implicitly in the patient's story. Any person could quickly learn to recite the symptom complex of peptic ulcer and could obtain hospital admission by appearing at the admitting office with a plausible story. There was no pain of digging into one's pocket to pay for the doctor or the hospital. There was no loss of wages for the period of hospitalization. On the contrary, at the Government's expense one could loll around a hospital ward, get good food and some entertainment. One could avoid unpleasant tasks, and also chances of hazardous duty (e. g. gangplank fever). If after 10 days to 2 weeks a diagnosis of organic disease was not made, you lost nothing. You were merely returned to duty after a pleasant vacation.

Probably a very small minority of our men would consciously take advantage of such opportunities. But of those men who came before the dispensary officer or the ward surgeon there were many who did try to capitalize on some minor complaint or who synthesized some symptom complex in order to avoid their responsibilities as soldiers. The doctor had to be on guard against gold bricks and malingerers. In contrast to the usual relations in civili life the patient found the doctor not on his side, but on the other side. The doctor had to be convinced. In those cases in which irrefutable evidence of disease was not obtained through laboratory procedures or X-rays, patients were discharged as "no disease," "functional" or "psychoneurotic." In some instances such diagnoses were correct and justifiable, but many seriously ill men were battered around from one medical officer to another, and from one service hospital to another without sympathetic treatment and without adequate care. There are thousands of former servicemen who will bear such testimony.

It should be emphasized that these deficiencies were in no way the fault of the Army or Navy. The services are to be congratulated upon obtaining the services of our medical men (some 60,000 of them) and giving them, for the most part, adequate supplies and facilities. These deficiencies are the direct consequence of the alteration of the usual relation between the doctor and his patient.

THE STATUS OF THE PHYSICIAN UNDER S. 1320

These threats to the freedom and well-being of the patients are accompanied by equal or greater threats to the freedom of the physician. Under the present system the doctor and the patient enter a temporary agreement for medical care. At any time, without prior notice, the patient may terminate the arrangement for any reason or for no reason. At any time the physician may choose to terminate the arrangement because the patient is not following directions faithfully, because the patient is unreasonable in his demands, because of conflict of personalities, or for any other reason. Neither party is obliged to justify his actions to some representative of the Federal Government. Neither party is in a position to coerce the other. Each party to the temporary arrangement is the equal of the other. Under the proposed plan (S. 1320) the physician does not have the status of an equal. He is answerable to the demands of the insured, whether reasonable or not, and subject to the rulings of an administrative employe of the Federal Security Administrator. The doctor could not dismiss a patient without having to justify his actions to the local representative of the Federal Health Agency, who will have it in his power to support the position of the patient or the position of the doctor.

The statement is often made by proponents of compulsory insurance that doctors will be free to join the enterprise or not as they choose. Such statement cannot be accepted by the medical profession. Mr. Altmeyer, chairman of the Social Security Board, has admitted in testimony before this committee (2) that in any community where a significant number of physicians elect not to participate, the governmental agency "would undertake to induce other physicians to come into the community who would be willing." This is truly forced labor. The Congress recently refused to grant to the President the power to draft labor temporarily when the vital services of our Nation were paralyzed by strikes. Is the Congress willing to deprive the physicians of this country of their freedom, not temporarily, but permanently?

The powers granted to the Federal Security Administrator and his lay personnel under the terms of S. 1320 are amazing to any one prejudiced in favor of a democratic form of government. It is significant that the all-powerful National Health Insurance Board would consist of 5 persons, only two of whom are required to be physicians. Inasmuch as all functions of this board would be administered under the direction and supervision of the Federal Security Administrator, and since one of the physicians on the board would be the Surgeon General of the Public Health Service, the representation on that board of practicing physicians would be a meager one. The advisory council, which is expected to advise the Security Administrator on regulations regarding professional standards, is also overwhelmingly a lay council. Of the 16 appointed members no more than 6 need be persons representative of the individuals who would be called upon to furnish the services. And not all of these six would have to be physicians or dentists.

According to the terms of S. 1320 the Federal Security Administrator, and his nonprofessional national insurance board and lay advisory council, would determine who is a specialist and who is not. They would pass on professional standards regarding the services rendered and set the fees for those services. They would determine how many patients each physician or dentist would care for. These nonprofessional, lay persons, would exercise control over the kind of medical and dental research to be done. No mention is made of deciding where graduates of our medical schools would be allowed to practice, and which of them would be allowed to take training for the specialties. But it is the avowed purpose of this bill "to promote more effective coordination among general practitioners, specialists and nurses * * *," and in the exent that the powers specifically granted to the Federal Security Administrator are not sufficient for his purposes, he is authorized to make "such other regulations not inconsistent with this title as may be necessary."

In the recent past the laity has acquired an erroneous idea of the importance of X-ray facilities and laboratory aids in medical practice. They have formed some very definite opinions on the relative need for specialists and group clinics. To be sure X-ray and laboratory facilities are essential, and it is quite true that in many communities such facilities should be expanded. However these laboratory aids are not at all infallible, even when they are applicable. And in many situations the employment of such aids yields meager returns. Group practice undoubtedly offers many advantages both to the patients and to the physicians concerned. But like all other arrangements the advantages are always accompanied by some disadvantages. It is still necessary for an individual to have a physician who not only understands his physical state, but who is thoroughly familiar with the relations of the individual to his working and home environment, and who feels a continued responsibility for the well-being of this patient. I doubt very much if the medical profession today would be able to give a satisfactory recommendation concerning the relative needs in each type of community for general practitioners or specialists practicing solo and for group clinics. I have no doubt that a lay person as Federal Security Administrator and his lay advisers would be in no position to make satisfying recommendations on such matters.

A WISER COURSE, SECURITY AND FREEDOM, TOO

With respect to the health of our people there are some major problems confronting us which dwarf all others. From the standpoint of our national economy, the common cold is of prime importance. But for the ultimate welfare of each individual the important diseases are those which cause prolonged disability and those which kill. The chief killers are heart disease, cancer, chronic vascular disease, nephritis, tuberculosis, and pneumonia (35). The chief causes for prolonged disability are mental disease, heart disease, tuberculosis, and vascular disease (35). The medical services of this country could be expanded to infinity without influencing one iota the incidence of these maiming and killing diseases. We cannot prevent their onset, and for most of them we have no cures. All that the medical profession can offer to those afflicted is a wise program of care which will enable the stricken individual to live a longer, more comfortable, and more useful life.

For some of these diseases, such as rheumatic fever, pneumonia, and tuberculosis, the frequency is definitely related to the housing and state of nutrition of the population. To the extent that nephritis and heart disease are associated with infections (streptococcal infections and rheumatic fever) they also are influenced by housing and nutrition. When one considers that heart disease is the leading cause of death in this country (about one out of four deaths), that it is among the leading causes for prolonged disability, that 20 to 40 percent of all heart diseases (depending upon the region studied) is of rheumatic origin, and that about 1 percent of all children have rheumatic heart disease (36) when we consider these facts the relative importance of housing and nutrition becomes more evident.

The greatest single cause for chronic invalidism in this country is mental disease (35). Although the precise causes and predisposing factors have not been isolated and identified, the incident of various kinds of mental diseases is also correlated with density of population, housing facilities, economic status, and social environment.

The physicians of this country are not responsible for our present housing conditions. They are not responsible for the inadequate educational facilities in many of our States. Neither by the administration of pills from a little bottle, by universal innoculations, by X-ray therapy, nor by the use of radio-active elements can your physicians quickly and cheaply erase the consequences of illiteracy, overcrowding, undernutrition, inadequate plumbing, and the widespread neglect of personal and public hygiene. Your physicians cannot completely shield the entire population from the effects of temporary or permanent economic maladjustments. We have not set the income limits for the lowest income groups—and these groups need to purchase not only medical care, but food, clothing, and shelter as well.

Our immediate problems will not be solved by the establishment of a fully staffed hospital or group clinic at every crossroad. Our purposes would not be accomplished by the elimination of economic barriers wherever they may be found. As Lee and Jones have said (9: p. 14)—"Public health is purchasable but the purchase involves a desire to purchase, the willingness as well as the ability to pay for it, and at least some understanding of what is being bought."

We need a careful and honest survey of our needs. We must determine in each locality whether the emphasis is needed on education, housing, nutrition, or sanitation, and the reinforcement of public-health measures. We should be in a position to decide whether to improve the local roads so as to bring the farmer more easily to the doctor, or to provide additional medical facilities so as to bring the doctor to the farmer. Senate bill 545 provides for such survey.

We have 48 States, each of which can be an experimental laboratory for the study of prepaid medical care. While these various local experiments are in progress more and more people will be covered by one kind of prepaid service or another. Less and less will the unpredictable costs of illness be a burden. If some State, with the consent of its people, decides to experiment with compulsory health insurance we might learn more of the virtues and the defects of such plan by actual trial. Through widespread public discussion of these various local experiments our people would become better informed. They would become more familiar with the problem and be in a better position to reach an intelligent decision.

The health of this Nation is not in such desperate state that we must rush to surrender the complete control of the medical care of our people into the hands of an all-powerful Federal agency.

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(Subsequently, pursuant to Senator Murray's request in hearing of July 2, 1947, the following reply to Dr. Friedman prepared by the Federal Security Agency was submitted:)

June 27, 1947.

Mr. Watson Miller,
Federal Security Administraior, Federal Security Agency,
Washington, D. C.

Dear Mr. Miller: During the hearings before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare held on June 25, a Dr. Maurice H. Friedman made several statements and introduced into the record figures and analysis thereof which—if accepted at face value—would raise serious doubt as to the validity of statistical analysis prepared by agencies under your administration.

These statements question many items heretofore regarded by students of medical economics as established facts upon which public action might be predicated. They challenge the value of materials compiled and interpreted by the United States Public Health Service and by the Social Security Administration. They call into question what I regard as the solidly established reputations for integrity and scholarship of Mr. George St. John Perrott, Chief of the Division of Public Health Methods of the United States Public Health Service, and of Dr. I. S. Falk, Director of Research and Statistics for the Social Security Administration. Even more important, in effect, they represent attacks on the integrity or intelligence of public servants in agencies under your administration and in other departments of Government—attacks on the reliability of documents issued by the Government of these United States.

Inasmuch as Dr. Friedman's testimony is a matter of public record, I regard this as a serious matter. I am asking Senator Smith, chairman of the subcommittee, to order the printing of Dr. Friedman's testimony delayed until you have had an opportunity to analyze it and to prepare such a reply as the facts and your interpretations thereof warrant. I hereby request that you submit such an analysis and reply to me for inclusion in the record. Should time permit your commenting on those portions of Dr. Friedman's testimony not relating directly to the work of agencies under your direction but which in your opinion might lead to false inferences, I would appreciate your including such comments in your reply.

I sincerely regret having to make this request of you but I am sure that you will agree as to its necessity.

For your convenience, I am enclosing a copy of Dr. Friedman's testimony and of the transcript which sets forth his remarks.

Sincerely yours,

James E. Murray.

Federal Security Agency,
Washington, July 23, 1947.

Hon. James E. Murray,
United States Senate,
Committee on Labor and Public Welfare,
Washington 25, D. C.

Dear Senator Murray: In accordance with the suggestion in your letter of June 27, 1947, there is transmitted herewith a detailed analysis of the testimony submitted by Dr. Maurice H. Friedman in connection with his appearance before your committee on June 25. It will be appreciated if this statement can be incorporated in the record of the hearings.

The Administrator is absent from the city. Were he here, I know he would want to express to you personally his appreciation for your kind consideration in making it possible for us to correct the record on this matter.

Sincerely yours,

MAURICE COLLINS,
Acting Administrator.

Enclosure.

ANALYSIS OF THE STATEMENT OF MAURICE H. FRIEDMAN, PH. D., M. D. TO THE COMMITTEE ON LABOR AND PUBLIC WELFARE, UNITED STATES SENATE, EIGHTIETH CONGRESS, JUNE 25, 1947, RELATIVE TO S. 545 AND S. 1320, PREPARED UNDER THE DIRECTION OF THE FEDERAL SECURITY ADMINISTRATOR

Summary and conclusions

The detailed statement submitted by Dr. Friedman seems to have the following general purposes:

(1) To question the validity of the data presented by various public and private agencies, which have demonstrated the extent of the unmet health needs of the Nation.

(2) To suggest that economic factors determining family purchasing power do not constitute the primary barrier to adequate medical care.

(3) To deprecate the value of timely and adequate health and medical care in reducing the burdens of disease and disability now carried by the population.

(4) To defend the thesis that certain types of voluntary prepayment plans for medical care are adequate for the Nation's requirements, and that national health insurance would serve only to produce deterioration in the medical standards of the country.

Dr. Friedman's contentions are discussed in some detail in the body of this report. At the outset, however, certain general observations may be made.

Dr. Friedman bases his conclusions on fragmentary analyses of certain documents relating to health needs—particularly certain reports of the Selective Service System, the Committee on the Costs of Medical Care, the National Health Survey, and the Senate Committee Print No. 4 prepared by the Social Security Board (now the Social Security Administration). In questioning the validity of these studies, Dr. Friedman ignores the fact that—with one exception—essentially similar findings have been reported by almost every other survey of health conditions conducted by agencies in and out of Government. Among the surveys that have presented data for various periods from 1914 through 1947 are: Reports of examinations of school children; the series of studies by the United States Public Health Service on the health status of families in Hagerstown, Md., and in cotton-mill villages of South Carolina: the summaries of morbidity data published by the Metropolitan Life Insurance Co.; data from the medical examinations of the Life Extension Institute; the health and depression studies of the Milbank Memorial Fund; the Nation-wide survey of the health status of youth in the National Youth Administration program; the study of farm families made by the Farm Security Administration; analyses of physical examinations in the draft for World War I and comparison of those findings with data from Selective Service examinations.

Through his incorrect analysis of certain selected statistics, Dr. Friedman attempts to discredit the findings substantiated by nearly all health studies made in this country; and, at the end of his testimony, he asks for "a careful and honest survey" of our needs. He furthermore minimizes the achievements of modern medicine by asserting that "the medical services of this country could be expanded to infinity without influencing one iota the incidence of * * * maiming and killing disease," including among these diseases tuberculosis and pneumonia. In our opinion, the challenging health needs of the economically insecure, the rural, and the Negro sections of our population are established beyond dispute. The 10-point health program of 1946 adopted by the American Medical Association, the statements presenting justification for both major pieces of pending health legislation and for the newly established hospital-survey and construction and mental-health programs—all are predicated on accepted evidences of unmet health needs in the United States and on confidence in the ability of medical science to improve the health of the population.

Basic evidence of the gaps to be filled in the American health scene is included in the objective recording of mortality data by the agencies concerned with vital statistics. Table A has been compiled to show the mortality rates for childbirth and four types of diseases in the 48 States. Attention is called to the wide discrepancies among the several States, and to the comparison of the extremes with the national averages. For example, more than half of the 89 persons per 100,000 population who died of pneumonia in Kentucky in 1944 might have been saved if they had had the medical facilities and attention available in the District of Columbia, where the mortality rate from that disease was less than 42 per 100,000 in the same year.

Statements issued by the United States Public Health Service, the Social Security Administration, and other units of the Federal Security Agency have stressed the high quality of medical services potentially available in the United States, but they have indicated that certain large segments of our population are unable to take full advantage of these services. This inability is, in large measure, to be attributed to three factors, singly or in combination: (1) The uneven and unpredictable incidence of illness and of needed care, (2) the frequent inadequacy of earnings to meet these costs, and (3) the shortages of medical personnel and facilities in many areas of this country. Careful analysis of Dr. Friedman's testimony fails to reveal any valid reason to abandon the conviction that unmet health needs and inadequate medical services exist in many parts of the Nation.

SUMMARY COMMENTS ON THE MAIN SECTIONS OF THE FRIEDMAN STATEMENT (BASED UPON DATA PRESENTED IN THE DETAILED REPORT HERETO)

Selective Service figures

Dr. Friedman's appraisal of the significance of defects found among men examined for military duty under the Selective Service System is in conflict with the opinion of the medical men in charge of the program, and disregards the conclusions derived from other data bearing on the subject. His classification of defects causing rejection to prove that only 20 percent were amenable to preventive or remedial services contradicts the experience of current medical and public-health practice. In this connection, Dr. Friedman apparently ignores the tremendous importance of medical care in the control, amelioration, and palliation of the great majority of medical disorders.

Negro and rural health conditions

Dr. Friedman uses Selective Service statistics to deny that Negroes have more ill-health than whites in general. He ignores the large body of evidence on this point as well as on the comparative health needs of rural population groups in comparison with urban groups—data on mortality, maternal and infant-death rates, rate of hospitalization, morbidity rates, and the like. In general, his use of Selective Service statistics to prove his points is faulty, in that he fails to appreciate the limitations of statistical procedure. Data available from Selective Service (despite their many actual limitations) undeniably reflect the greater prevalence of defects among rural and Negro groups in comparison with the urban and the white population.

Medical personnel and facilities

In this section, Dr. Friedman attempts to show that there is no significant maldistribution of medical personnel or facilities—or that the maldistribution is not as serious as some have asserted. In the first place, he misinterprets the study made by Lee and Jones on the standards of good medical care. Instead of requiring 1 physician to each 1,200 persons, as Dr Friedman reports the data, the ratio for adequate care should be 1 to 742 persons. Instead of four States with less than an adequate number of physicians, there are at least 40. Dr. Friedman is correct in stating that a county is not the most satisfactory unit for measuring adequacy of facilities. But even when the United States is divided into districts similar to those recommended, few areas actually have the adequate ratio of physicians to population.

With regard to hospitals, Dr. Friedman stresses the fact that the States with the fewest relative number of hospital beds also have the lowest occupancy rates. These, however, are the States with the lowest per capita income; the limited use of hospitals in these States reflects the relatively large numbers of people who cannot afford to pay for hospital care, as well as the lack of free beds and adequate tax funds to support the hospitals. Congress has recently approved the Hill-Burton Hospital Survey and Construction Act to improve this situation, in an effort to correct existing inequities in the availability of hospital facilities.

Economic barriers to medical care

Dr. Friedman questions the validity of the statement that lack of funds raises a barrier to adequate medical care. He cites the Committee on the Costs of Medical Care finding on the proportion of the surveyed population who reported no illness during the study year as contrasted with those who received no care of any kind.

If Dr. Friedman had used the data from the same survey which show the differences among income groups—instead of using the average for all income levels, which tend to cancel differences between the rich and poor—he would have noted the significantly larger proportion of persons in low-income families who had no medical care of any kind in the survey year. Opinions of doctors and dentists on the value of periodic examinations and preventive services indicate that few persons, if any, should go for a whole year without such attention. Moreover, the results of medical and dental examinations reveal the extent to which people are unaware of ailments and defects that may prove serious if they are neglected. There is conclusive evidence that fear of costs is a barrier to the receipt of medical attention, and that inability to pay for medical service usually means that people wait until they are seriously ill before they call a doctor.

The incidence of illness

In discussing this subject, Dr. Friedman attempts to prove that there is little or no relation between income and illness. For this purpose, he relies mainly on the study made by the Committee on the Costs of Medical Care, ignoring a vast number of surveys that have shown beyond reasonable doubt that morbidity is higher among the poor. He overlooks the fact that the Committee on the Costs of Medical Care data showed that the "total days of disability per person and per case of disabling illness in the lowest-income group is over twice that in the highest."

Dr. Friedman explains that the higher incidence of illness in the highest income groups in the Committee on the Costs of Medical Care Survey is possibly due to the greater percentage of older persons in these groups, but then disparages the very process of adjustment for age by which the different income groups are made comparable in the studies cited. The National Health Survey found that illness rates were very much higher among families on relief than among nonrelief families. Dr. Friedman ascribes these findings to the inexperienced enumerators who collected the data and the methods used to adjust illness rates. Unadjusted rates, however, many of which are shown in the survey report, are similar in size and direction to the adjusted rates. The enumerators were carefully trained; the method of their training is set forth in detail in the report Dr. Friedman cites as the source of his information.

Volume and distribution of medical services

In this section, Dr. Friedman makes two assumptions: (1) That "if the medical care received by a family were largely dependent upon the family income the volume of medical services received should rise steadily with rising income," and (2) that "if all kinds of medical service were equally influenced by considerations of cost, the rise in volume with rise in income should be approximately the same for all kinds of medical care." He then attempts to show, through use of Committee on the Costs of Medical Care data on the volume of various types of service received in different income groups, that there is little if any correlation between income and the volume of services received under the present system of medical care.

Only when care is generally of a nonemergency nature and largely dependent on the individual's choice (for example, dental and nursing service), however, is there a steady rise with income in the frequency with which medical service is obtained. The receipt of free service, especially hospital care, by persons in families with lower incomes, as repeatedly stressed in Committee on the Costs of Medical Care reports, markedly influences the rate with which the volume of care increases from low to high income levels. The important consideration is not the uniformity with which the volumes of the several kinds of service increase with increased income, but the wide difference in the amount of service received by the low as compared with the high income groups.

Unattended and recorded illness

Dr. Friedman questions whether we should be greatly alarmed that one-third of illness was unattended (as found in the committee on the costs of medical care study) when it is recalled that over half of the recorded illnesses were ambulatory, and that almost half were not disabling. These criteria, however, are not sound bases for determining whether an illness needs medical attention or not. Most health examinations, preventive services, eye examinations, and dental treatments are given to ambulatory patients, and few doctors would advise patients to wait until they are disabled before they call for medical services.

The major question is not whether all illness receives medical attention, but how much illness that should receive care is not getting it. Since the volume of care and number of attended illnesses increase with income, a fact that Dr. Friedman admits, there is little validity for his contention that the effect of income on illness and the amount of unattended illness is insignificant. The significant point is, that when compared with higher income families, persons in low income groups lack medical services.

The costs of medical-care insurance

To calculate the costs of a health insurance program, Dr. Friedman uses estimates of the cost of adequate medical care, provided by Bradbury and based on Lee-Jones standards of adequacy, and estimates of actual medical expenditures in 1929.

Recent estimates of the total and per capita costs of a health insurance program—based on the services to be provided and the estimated demand for such services—are presented in Senate Committee Print No. 5, Medical Care Insurance; A Social Insurance Program for Personal Health Services. Health insurance services could be provided at a total cost not substantially greater than the total amount now being spent by individual families for the same classes of services. The difference would lie in the fact that the amount would be more evenly divided among families and better related to income than under the present postpayment system. It is recognized that a health insurance program would not assure completely adequate care to all persons, since certain limitations would have to be set for some of the services provided; but under health insurance, more people could receive more adequate care at a cost more nearly within their means.

Family payments for medical care

Dr. Friedman bases his entire discussion in this section on the assumption that each family, under a health insurance system, would contribute an equal annual amount (assumed to be $100) to the program. He has failed to recognize that such a figure (even assuming it to be a reasonable one) represents only an estimated *average* for all families. Under a health-insurance arrangement, of an American pattern, each family's contribution would be determined by its income. The lower the family income, therefore, the lower the amount contributed. Dr. Friedman's assertion that farm families can now afford adequate medical services squares neither with agricultural income data nor with the known experience of health workers in rural communities.

Voluntary prepayment plans

Dr. Friedman suggests that certain voluntary prepayment plans are capable of meeting the existing health needs of the Nation. His discussion of existing plans, however, gives no evidence to support his assertion that Blue Cross and medical society plans can provide adequate medical care on a prepayment basis for the total population. Furthermore he fails to give serious consideration to the limitations of such plans and places most emphasis on distinctly atypical plans in the State of Washington.

The contributions of existing voluntary medical care programs are undeniable. Their shortcomings of coverage, services, costs, and organization are, however, sufficient to cast serious doubt on the possibility of their ever constituting an adequate health program for the entire Nation.

Reflections on S. 1320

In this section and those that follow, Dr. Friedman condemns the national health insurance and public health bill of 1947 on the grounds of incompleteness of benefits, excessive administrative costs, Federal bureaucratic control, lack of freedom for doctors and patients, opportunities for malingering, and the general limitations of available medical knowledge.

Dr. Friedman's interpretation of many of the provisions of S. 1320 can readily be disproved by referring to the appropriate sections of the bill. The nature of his comments on administrative costs in foreign countries and on the experience of the Rhode Island disability insurance program are actually gross distortions of the existing facts. Disagreement with S. 1320 is certainly Dr. Friedman's prerogative, but a large proportion of his statements on the proposed program are erroneous.

In summary, Dr. Friedman's treatment of selected health survey data does not invalidate the generally accepted evidence of health and medical care deficiencies in this country. Further proof of his inability to substantiate his claim that this country faces no serious need for comprehensive health care planning at this time is presented in the more detailed discussion of the main sections of his statement, which is appended.

TABLE A.—*Mortality in 1944, by place of residence*

[Not adjusted for age]

	Number per 1,000 live births		Number per 100,000 population					
	Infant mortality	Maternal mortality	Total mortality	Tuberculosis	Cancer	Diabetes	Diseases of heart	Pneumonia
United States	39.8	2.3	1064.7	41.3	129.1	26.4	315.4	61.7
Alabama	45.5	3.7	928.6	45.0	73.9	11.7	181.2	73.7
Arizona	68.8	3.0	972.7	122.9	80.9	8.3	170.7	68.8
Arkansas	34.7	2.8	817.3	46.5	74.4	11.0	169.4	68.1
California	34.5	1.7	1,037.0	43.7	131.8	21.6	327.1	53.2
Colorado	49.4	2.5	1,068.7	36.5	126.2	19.2	277.9	82.9
Connecticut	30.7	1.5	1,065.5	37.2	165.6	35.4	357.6	44.0
Delaware	48.7	1.5	1,177.7	43.3	126.8	29.9	359.8	65.1
District of Columbia	44.8	2.1	880.7	58.6	115.1	22.3	247.1	41.6
Florida	45.5	3.3	992.0	34.7	92.4	17.4	222.2	62.8
Georgia	44.5	3.6	912.4	35.4	71.1	11.9	177.9	71.6
Idaho	34.0	2.5	876.2	20.4	100.3	17.8	229.1	54.2
Illinois	32.4	1.8	1,140.6	41.6	160.6	34.0	399.6	43.5
Indiana	34.5	2.0	1,151.8	35.7	135.0	27.7	334.4	65.1
Iowa	33.1	1.8	1,149.8	15.0	157.9	28.3	354.7	66.1
Kansas	33.3	1.8	1,044.8	20.1	130.0	27.0	297.9	53.3
Kentucky	46.7	2.5	1,079.7	65.7	102.9	18.6	264.2	89.3
Louisiana	46.3	3.4	929.9	45.7	92.6	16.1	245.0	68.8
Maine	46.7	2.3	1,295.1	35.2	170.0	25.6	381.6	73.3
Maryland	41.5	1.9	1,064.5	62.3	122.0	28.6	324.2	58.8
Massachusetts	33.1	1.8	1,241.5	40.8	182.7	37.5	448.2	66.8
Michigan	37.9	1.7	1.001.9	33.4	128.0	26.8	313.2	52.6
Minnesota	31.3	1.4	1,053.8	27.6	149.6	29.0	321.5	67.5
Mississippi	44.1	3.8	949.6	38.2	74.2	13.6	164.2	65.0
Missouri	37.6	2.2	1,177.1	41.4	146.6	25.2	350.3	84.9
Montana	36.1	1.5	1,218.0	37.6	146.5	27.1	357.1	64.5
Nebraska	33.0	1.7	1,037.5	17.4	137.1	27.4	297.1	59.7
Nevada	50.2	2.3	1,053.2	48.6	101.0	12.8	229.6	68.4
New Hampshire	37.7	2.8	1,353.7	23.0	187.4	38.9	446.4	80.7
New Jersey	34.0	1.6	1,147.4	44.5	165.2	35.6	392.3	49.1
New Mexico	89.1	4.0	1,034.1	64.9	63.6	10.2	144.6	82.9
New York	32.8	1.9	1,205.9	47.9	178.7	42.6	453.7	52.0
North Carolina	45.4	2.9	832.2	35.1	65.9	14.4	180.9	56.4
North Dakota	35.4	1.8	968.6	16.3	123.2	28.0	263.2	52.4
Ohio	38.5	1.9	1,173.6	40.8	146.8	32.4	356.5	66.1
Oklahoma	41.2	2.4	917.0	42.6	99.8	16.3	205.8	61.7
Oregon	30.5	1.8	1,083.6	25.3	137.3	21.8	306.9	58.9
Pennsylvania	40.0	2.5	1,194.5	43.5	151.1	36.6	385.2	71.2
Rhode Island	35.3	1.8	1,075.6	38.4	137.4	37.2	385.0	57.0
South Carolina	54.9	3.7	945.0	34.4	66.1	16.3	188.1	75.4
South Dakota	34.9	1.8	1,011.7	31.9	129.6	23.5	267.3	56.8
Tennessee	45.5	2.8	971.2	65.6	89.0	13.1	209.4	78.9
Texas	50.4	2.5	894.9	45.4	82.2	14.6	196.0	62.0
Utah	33.9	1.4	817.5	12.0	90.0	18.3	243.4	42.2
Vermont	40.6	1.9	1,373.6	39.9	169.4	35.4	441.3	69.4
Virginia	47.1	2.6	898.7	42.0	81.2	17.0	224.5	61.6
Washington	33.8	1.6	1,062.1	34.1	129.2	22.3	327.1	59.2
West Virginia	52.0	2.2	968.8	44.6	89.2	18.5	224.5	69.3
Wisconsin	32.0	1.8	1,064.7	24.4	152.2	32.3	333.6	55.4
Wyoming	41.2	.9	887.3	13.2	94.3	21.0	232.2	53.8

TABLE A.—*Mortality in 1944, by place of residence*—Continued

[Not adjusted for age]

	Number per 1,000 live births		Number per 100,000 population					
	Infant mortality	Maternal mortality	Total mortality	Tuberculosis	Cancer	Diabetes	Diseases of heart	Pneumonia
Low State	Oregon 30.5	Wyoming 0.9	Arkansas 817.3	Utah 12.0	New Mexico 63.6	Arizona 8.3	New Mexico 144.6	District of Columbia 41.6
High State	New Mexico 89.1	New Mexico 4.0	Vermont 1,373.6	Arizona 122.9	New Hampshire 187.4	New York 42.6	New York 453.7	Kentucky 89.3

Source: Maternal mortality by age and race, United States and each State, 1944, Vital Statistics—Special Report, vol. 25 No. 7, Department of Commerce, Census, June 26, 1946. Vital Statistics of the United States, 1944, pt. II, U. S. Department of Commerce, Bureau of Census, 1946, tables I and J.

THE DRAFT REJECTION FIGURES

In his analysis of selective-service data, Dr. Friedman attempts to prove that they give no real indication of the health of our people. His conclusion is in sharp conflict with that of Col. Leonard G. Rowntree, the Chief of the Medical Division of the Selective Service System, as well as with the opinions of most authorities in the field. Colonel Rowntree, a physician of very high standing, said in his testimony before the subcommittee of the Committee on Education and Labor of the United States Senate, Seventy-eighth Congress:[1]

"The amazing conditions revealed by the selective-service statistics, as in the physical fitness of the Nation, is a challenge to the medical profession particularly, and to all interested in national health and national morale, in the future of the Nation and its youth. The conditions call for both a remedial and a preventive program. Everything should be done that can be done to improve the surprising conditions that have been revealed, and more must be done to prevent similar conditions developing in the rising generations.

"The sociological and economic factors are indissolubly bound up with the availability and utilization of good medical care. We are not the vigorous people that we thought we were. The people must be educated to accept the fact that we have a high percentage of defects, deficiencies, disabilities, disorders, and diseases. We must be educated to demand medical care in proportion to the demonstrated need of that care."

On the specific point of limited income as a deterrent for adequate medical care, Colonel Rowntree made the following statement:

"* * * There is no question but that the cost of medical care is a factor in a very considerable proportion of those suffering from defects, illnesses, and disease * * *."

The preceding quotations were taken from Colonel Rowntree's prepared written testimony. In his oral statement he said:

"Now, when the first figures appeared, they were accepted with a gseat deal of skepticism on the part of everyone, particularly on the part of the medical profession. There seemed to be a desire on the part of most people, and many of them in high places, to explain these figures away as of no great consequence. However, as the high rate of rejections continued to swell, it became obvious to everyone that this was a problem that could not be overlooked and that demanded national attention."[2]

At the outset, Dr. Friedman calls into question a statement in Senate Committee Print No. 4 (1946) that a half to two-thirds of the defects revealed by selective service examinations could have been prevented or rehabilitated with timely care.[3] This statement was based on many facts. In the first place, the Army medical staff had already rehabilitated 1.5 to 2 million men with defects that had caused rejection,[4] but these men did not include all with preventable defects.

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[1] Hearings before a subcommittee of the Committee on Education and Labor on S. Res. 74 (78th Cong., 2d sess.), pt. 5, pp. 1638–1639.

[2] Ibid., p. 1640.

[3] U. S. Senate, U. S. Senate Committee on Education and Labor: Need for Medical Care Insurance; Report to the Committee on Education and Labor, Senate Committee Print No. 4 (79th Cong., 2d sess.), March 1946, p. 5.

Colonel Rowntree has stated that:

"It is felt that from 15 to 20 percent of men rejected for military service are rejected because of disqualifying defects which could have been easily remedied. At the present time, we are not ready to estimate the preventable defects. The present IV-F pool amounts to 4,200,000 men. Conservatively, I would estimate that 700,000 of these men are rejected for remediable defects. This means 1 out of every 6 men in the present rejected pool."

It is also significant that successful local programs of rehabilitation have been carried on in New York City, Illinois, Mississippi, and elsewhere.[5]

Significance of Selective Service sample

Despite Dr. Friedman's statement to the contrary, official analyses of selective service data always point out that the group examined was not fully representative of the total male population in the age groups 18-37. Dr. Friedman argues that the statements in the Senate Committee Print No. 4 are exaggerated since they take no account of the 2.7 million who enlisted. Any attempt to estimate the total number of men in ages 18-37 with defects which would cause rejection, however, would not only have to consider the 2.7 million without such defects who enlisted, but also make an appropriate correction for the age factor involved in the elimination of the deferred group. A large proportion of the 37.5 percent who were deferred were in the advanced ages and as a result their defect rates would have been much higher.[6] The addition of the deferred group would more than offset the reduction in rejection rates caused by adding the 2.7 million men who enlisted.

The statement in Senate Committee Print No. 4 did not attempt to generalize the findings of selective service for the entire age group that were subject to military duty. In his attempt to do this, Dr. Friedman has taken account of the factor that would reduce the rejection rate, but has disregarded the equally important counteracting factor which would increase that rate.

Factors governing rejection rates

The publications cited by Dr. Friedman emphasize the *prevalence of defects* found among men examined under the Selective Service acts and not the *proportion of men rejected* at any given period. Regardless of the rejection rate, however, a very large proportion of our male population was found suffering from many serious defects at ages in which health status should be at its best. As a matter of fact, the decrease in rejection rate, to which Dr. Friedman refers, was due not only to less exacting physical standards, but also to several other factors such as the extension of the draft to ages 18-21 and the admission of certain proportions of persons with defects to be rehabilitated after induction. It should be noted that this decrease was temporary only.

Analysis of causes of rejection

In his attempt to prove how little medical science can do to prevent or cure the defects found among IV-F's, Dr. Friedman classifies causes of rejection in six groups, discussed below:

1. *Conditions beyond the province of the medical profession.*—In this group, Dr. Friedman includes syphilis and gonorrhea. It is hard to believe, in 1947, that a physician could say that "the provision of adequate medical service, completely free of charge, will not prevent these (venereal) diseases, nor will such provision significantly lower the incidence of these diseases among our people."

In his table on conditions beyond the province of the medical profession, Dr. Friedman shows that syphilis and gonorrhea constituted nearly half of the rejected cases in the period A (April 1942–March 1943), before the Army had started its large-scale rehabilitation services for venereal-disease cases.

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[4] Hearings before a subcommittee of the Committee on Education and Labor on S. Res. 74, op. cit., p. 1637.

[5] Ibid., pp. 1635 and 1636.

[6] For the period September 1942 to June 1943, the rejection rate for men at age 18 was 27.6, at 19, 25.2, and increased progressively from there on to 39.4 at age 27, 43.5 at age 30, and 55.4 at age 37. Selective Service System: Medical Statistics Bulletin No. 3, p. 9.

About a decade ago, Surgeon General Parran called attention to the success achieved by Scandinavian countries in reducing syphilis to such relatively minor significance that there was "little syphilis to treat." He then said of the United States, "No matter how excellent the alibis or the little that we have done to control syphilis, nobody denies that it can be done."[7] In 1941, he wrote:

"The prime wasters of manpower are the venereal diseases, especially syphilis and gonorrhea. These diseases do enormous human damage, cost enormous sums. We know precisely how to cure them and have made a fair beginning at ridding ourselves of them."[8]

It seems clear that the problem of venereal disease in this country has been and will continue to be significantly reduced with proper case finding and treatment to decrease the effective number of infectious persons, and with early control of the infections to prevent the serious complications of their later stages. If there is any doubt of the important effect of diagnostic and treatment facilities on syphilis, one need only observe the marked reduction since 1938 in adult and infant mortality from syphilis and in the admission of syphilitics to mental hospitals. It was in 1938 that the Venereal Disease Control Act was passed. There is no reasonable basis, in the light of modern medical knowledge, for placing these diseases in the category of conditions beyond the province of the medical profession.

It is similarly inappropriate to class all mental deficiencies as conditions beyond the province of the medical profession. In the opinion of experts, a significant proportion of mental deficiencies are of environmental origin[9]—some resulting from birth injuries. Certain types of mental deficiencies like cretinism are susceptible to correction by early and appropriate medical care. Some cases of educational deficiency may result from physical disease or defects which prevent school attendance. Dr. Friedman, therefore, has little justification for including these defects in their entirety in his category 1.

2. *Conditions not preventable and not remediable by means available to medical profession now.*—In this category, Dr. Friedman includes all mental disease which in the selective-service classification included psychoneurosis and other minor as well as major abnormalities of behavior.

We have learned from the Army medical services that, of the men who received medical attention during the war for neuropsychiatric complaints, 30 percent or so were discharged from the armed forces and the remaining—nearly 70 percent—were rehabilitated and returned to duty. Results in prewar years were essentially the same, showing commitment for neuropsychiatric conditions in the Army at the rate of 15 per 1,000 strength and discharge at a rate of 4 per 1,000. The balance, 11 per 1,000 strength, except for a very small number of deaths, were recoveries—confirming the approximate 70-percent recovery rate observed during the war. Unquestionably, some of the men who were rejected for mental disease were of the border-line types of cases which, as the Army experience shows, might have been cured by early medical attention.

The Veterans' Administration statistics on neuropsychiatric cases for the fiscal year 1946 show a total of 37,890 who were medically discharged after the completion of hospitalization. Of these patients, 8.4 percent were classed as recovered and cured and an additional 71.6 percent as improved.

The recovery rate and the proportion discharged as improved was higher for World War II veterans than for veterans of earlier wars, as shown in table B.

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[7] Parran, Thomas, M. D.: Shadow on the Land: Syphilis, sp. educ. ed., New York, Reynal and Hitchcock, Inc., 1937, pp. 90, 246.

[8] Parran, Thomas, M. D., and Vonderlehr, R. A., M. D.: Plain Words About Venereal Disease, New York, Reynal and Hitchcock, 1941, p. 1.

[9] Myerson, Abraham, M. D., professor of neurology, Tufts College Medical School, with the collaboration of Henry B. Elkind, M. D., director of the Massachusetts Society for Mental Hygiene; Louis Ullian, M. D., assistant visiting physician, Boston City Hospital; and Hannah Smith, field worker: Research in Feeble-Mindedness and Special Relationship to Inheritance. Bulletin of the Massachusetts Department of Mental Diseases, vol 14, pp. 108–229 (April 1930).

TABLE B.—*Condition on discharge of veterans hospitalized for neuropsychiatric complaints, fiscal year ending 1946* [1]

Type of discharge and condition on discharge	All discharges			Veterans of World War II			Other		
	Cases	Percent	Percent	Cases	Percent	Percent	Cases	Percent	Percent
All hospital treatment	50, 246	100.0		34, 207	100.0		16, 039	100.0	
Hospitalization complete	37, 890	75.4	100.0	26, 451	77.3	100.0	11, 439	71.3	100.0
Result of treatment:									
Recovered or cured	3, 192	6.3	8.4	2, 273	6.6	8.6	919	5.7	8.0
Improved	27, 114	54.0	71.6	19, 993	58.4	75.6	7, 121	44.4	62.3
Unimproved	3, 048	6.1	8.0	2, 072	6.1	7.8	976	6.1	8.5
Died	2, 269	4.5	6.0	267	.8	1.0	2, 002	12.5	17.5
Condition not stated	2, 267	4.5	6.0	1, 846	5.4	7.0	421	2.6	3.7
Hospitalization incomplete	12, 356	24.6	100.0	7, 756	22.7	100.0	4, 600	28.7	100.0
Result of treatment:									
Apparently recovered or cured	404	.8	3.3	202	.6	2.6	202	1.3	4.4
Improved	4, 292	8.5	34.7	2, 444	7.2	31.5	1, 848	11.5	40.2
Unimproved	5, 603	11.2	45.3	3, 523	10.3	45.4	2, 080	13.0	45.2
Condition not stated	2, 057	4.1	16.7	1, 587	4.6	20.5	470	2.9	10.2

[1] Average number of neuropsychiatric patients during the year numbered 47,018; of these 13,991 were of World War II.

Source: VA Form 2593.

Even in the most serious cases—psychotics committed to State institutions for the insane—there are recoveries. The New York State Department of Mental Hygiene shows that of the patients discharged during the fiscal year 1944, 20.2 percent had recovered, 18.7 percent were much improved, and 10.3 percent were improved. Discharges constituted 24.1 percent of the average number of patients on the books during the year. Detailed figures for the fiscal years 1943 and 1944 are shown in table C.

TABLE C.—*Condition on discharge of patients in mental hospitals—New York State, 1943–44* [1]

Condition on discharge	1943		1944	
	Number	Percent	Number	Percent
Total	12, 797	100.0	17, 424	100.0
Recovered	2, 635	20.6	3, 518	20.2
Much improved	2, 540	19.9	3, 268	18.7
Improved	1, 401	10.9	1, 794	10.3
Unimproved	542	4.2	604	3.5
Without psychosis	160	1.3	166	1.0
Died	5, 519	43.1	8, 074	46.3

[1] Average number of patients in mental hospitals, 72,918 and 72,410 for 1943 and 1944, respectively.

Source: New York State Department of Mental Hygiene; fifty-fifth and fifty-sixth annual reports for periods July 1, 1942 to Mar. 31, 1943 (p. 205) and Apr. 1, 1943, to Mar. 31, 1944 (p. 200).

Similarly, 1944 statistics for the Nation as a whole show that of the 54,194 discharges of patients with psychosis, 29.5 percent were recovered and 57.2 percent were improved at the time of discharge (table D).

TABLE D.—*Condition on discharge of psychotic patients in State, county, and city mental hospitals, United States, 1943–44*[1]

Condition on discharge	1943		1944	
	Number	Percent	Number	Percent
All conditions	57,098	100.0	54,194	100.0
Recovered	17,379	30.4	16,006	29.5
Improved	33,081	58.0	31,004	57.2
Unimproved	5,617	9.8	5,938	11.0
Unclassified	1,021	1.8	1,246	2.3

[1] Average number of patients in State, county, and city mental hospitals, 505,283 and 509,866 for 1943 and 1944, respectively.

Source: Bureau of the Census; Patients in Mental Institutions, 1943, pp. 26–27, 5; 1944, pp. 25–26, 5.

At present, of course, State and municipal institutions for the insane are primarily custodial institutions with very limited facilities for effective therapy, and, by and large, only the most advanced or serious cases are committed to these institutions. Nevertheless, there are some recoveries. Far more important, however, is the evidence from Army experience on recovery among incipient cases for which immediate medical attention was available. Here the prospect of recovery is much greater and more significant for comparison with Selective Service findings, since only a small proportion of the 17.7 percent of IV–F's rejected for mental disease constituted[10] part of the psychotic patients in mental institutions.

Dr. Robert Felix, Chief of the Mental Hygiene Division of the United States Public Health Service, has the following comment to make on Dr. Friedman's statement regarding mental diseases:

"If this implies that adequate health measures, preventive and curative, could not have appreciably lowered draft rejections from nervous and mental diseases, this office would like to go on record to the contrary."[11]

There is, therefore, sufficient evidence to indicate that the rejection rate for mental and probably for neurological conditions would have been much smaller had the population subject to the selective-service examination received adequate and timely medical care, during the years before they were called for examination.

Similar criticism applies to most other classes of diseases and defects which Dr. Friedman places in this category. Few physicians would defend the surprising thesis that early and adequate medical care could not have prevented some of these causes of rejection. To cite but a few illustrations, cases of defective vision (for example, those resulting from ocular infections or injuries which were not adequately treated); some of the cardiovascular diseases (such as those caused by bacterial endocarditis or syphilis), some amputations and cases of ankylosis (when the treatment of the causative injury or disease was delayed or inadequate). Yet, Dr. Friedman makes no allowance for the possibility that the defects of some of the men rejected for the conditions in this category might have resulted from these causes.

Nor is there scientific basis for the claim that no treatment is of any remedial value in such disorders as sinusitis, nasal deformities, asthma, epilepsy, arthritis, congenital defects, underweight, and many other conditions that Dr. Friedman has listed as hopeless. Surely, he must know of some of the medical advances in ophthalmological and nasal surgery, use of antibiotics, endocrine therapy, plastic reconstruction, nutrition guidance, and the like.

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[10] Selective Service System: Estimated Principal Causes for Rejection of Registrants 18–37 Years of Age in Class IV–F and Classes With "F" Designation, August 1945 (Processed).

[11] See letter from Dr. R. A. Felix to the Federal Security Administrator, July 9, 1947, attached to this statement as appendix A.

Furthermore, Dr. Friedman's statement completely ignores the important fact that modern medicine can control and alleviate many conditions which are not actually "curable." Medical care in these instances is the difference between invalidism and normal life, between pain and comfort. Examples are corrective eyeglasses, allergy desensitizations, proper care of children with acute rheumatic fever, use of antiepilepsy drugs, fitting of orthopedic prostheses for amputees, provision of pain-controlling medication, prescription of proper peptic ulcer regimes, administration of insulin for diabetes, thyroid for myxedema, and the like. Can it be reasonably argued that these measures are unimportant to the sick person—or to the Nation's health? In his own consultation room, Dr. Friedman would find it difficult to send away nephritic or hyperthyroid or asthmatic patients with the admonition that nothing can be done for them. Yet, such conditions are listed in his category 2.

In a special statement[12] referring to the Friedman document, the American Heart Association commented:

"On the basis of present knowledge, adequate health measures, preventive and curative, could have lowered draft rejections for the various cardiovascular disorders * * * listed."

The experience of the crippled children's program, financed in part by Federal funds under title V of the Social Security Act, has resulted in the complete correction of thousands of congenital defects such as clubfoot, harelip, and cleft palate. Yet Dr. Friedman classes almost all congenital defects among conditions as not remediable by the medical profession now. When truly remediable and/or preventable conditions are excluded from category 2, the percentage of conditions appropriately in this class would be considerably less than the 43 or 50 percent claimed by Dr. Friedman.

Finally, it must be stressed that the undeniable prevalence of disorders which are beyond the current abilities of medical science is in itself the greatest spur to the hope that future research will bring more diseases under effective control. Certainly, the present limitations on medical knowledge should not constitute a barrier to better distribution of the services that are available.

3. *Possibly preventable.*—In this category, Dr. Friedman includes tuberculosis; hence, he must have real doubt of the tremendous advances that have demonstrated the feasibility of controlling this disease through coordinated medical-social action. Dr. Louis I. Dublin, statistician and vice president of the Metropolitan Life Insurance Co., has forcefully thrown down the challenge:

"The virtual stamping out of the disease [tuberculosis] waits upon the full utilization of existing knowledge and facilities for discovering and treating cases."[13]

4. *Not preventable but correctible.*—It should be here noted that certain types of hernias are preventable. Because of Dr. Friedman's blanket denial of the ability of modern medicine to correct many other conditions, his list under this heading is obviously very incomplete.

5. *Preventable and/or correctible.*—In this category Dr. Friedman should have included such conditions as syphilis, gonorrhea, certain types of mental deficiencies, which he placed in category 1, and an appreciable number of the diagnostic groups which he classified wholly or partially in his category 2.

6. *Undetermined.*—On the basis of data used by Dr. Friedman, many categories classified in 1, 2, and some in 4 and 5 belong here, since the specific information given is not sufficient to enable one to classify the defect in one of the first five categories.

Dr. Friedman concludes from his tables and discussion, that "about two-thirds of the rejections (sums of categories 1 and 2) were for causes which are beyond the powers of the medical profession to prevent or correct, regardless of the cost of medical care * * *." That proportion, however, is based on his unwarranted classification of venereal disease, clubfoot, diabetes, and the like, as conditions beyond the province of the medical profession. Dr. Friedman further concludes that only about 20 percent of the rejections for period A and 18 percent of the rejections for period B could have been influenced by medical care. This conclusion does not at all follow, since by his own admission some of the 10 to 12 percent in category 6 belong in categories 3, 4, or 5 and, as everyday medical experience shows, a significant proportion of defects listed in categories 1 and 2 belong in categories 3, 4, or 5.

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[12] See letter from Charles A. R. Connor, M. D., medical director of the American Heart Association, to the Federal Security Administrator, July 9, 1947, attached hereto as appendix B.

[13] Metropolitan Life Insurance Co.: Wiping Out Tuberculosis in Our Time, statistical bulletin of the Metropolitan Life Insurance Co., vol. 27, No. 11, November 1946.

REJECTION AMONG NEGROES AND THE POPULATION OF SOUTHERN STATES

In this section, Dr. Friedman places special emphasis on his belief that Selective Service data fail to show a higher proportion of curable defects among rejected Negroes than among white persons. This conclusion, of course, inevitably results from his classification of curable defects, since a very important principal cause for Negro rejection was feeblemindedness combined with or indistinguishable from educational deficiency and venereal diseases—conditions which, according to Dr. Friedman, are beyond the province of the medical profession. Evidence of the fallacy of such classification has been presented in the preceding pages.

Despite Dr. Friedman's contention, the fact still remains that, on the basis of Selective Service experience, a higher proportion of Negroes than of white men were rejected for military service because of physical and mental defects. All the evidence from Selective Service data supports this statement. This evidence, moreover, accords with other data, such as the higher mortality rates for Negroes, which are to be found in the periodic reports of the National Office of Vital Statistics, and also in the higher morbidity rates for Negroes shown by the national health survey.[14]

In an analysis of morbidity rates of Negroes and whites, Holland and Perrott concluded:

"In the 12-month survey period, the amount of disability per person due to illnesses which incapacitated for a week or longer was 43 percent higher in the Negro than in the white population. * * * The improvement in standard of living which is associated with a rising income increased the health status of the Negro as measured by the various indices of illness, the average Negro in the nonrelief class experiencing only one-half as much disability per year as the average Negro on relief. Low economic status, rather than inherent racial characteristics in the reaction to disease, thus appears to account in large measure for the higher disability rate observed among Negroes." [15]

Dr. Friedman cites the data on tuberculosis prevalence in examined registrants as an example of the more favorable findings for Negroes. While it is true that for all ages between 18 and 46 years the prevalence of tuberculosis was 19.9 per 1,000 for white persons and 14.6 for Negroes, it must be remembered that the highest incidence and greatest mortality from tuberculosis in Negroes occurs in the early years of youth, before the ages of most men in the Selective Service sample. Mortality among Negroes aged 20 is actually 10 times that among white persons. Selective Service figures themselves showed that in the 18-to-19-year-old group, the prevalence of tuberculosis was 7.7 per 1,000 among whites and 11.5 among Negroes. The high mortality among young Negroes would seem to mean a shorter duration of illness with a greater fatality, which may well reflect the lack of adequate medical care, preventive as well as curative.

Aside from limitation of data for individual diagnostic groups, Dr. Friedman's whole approach is faulty. The conclusions which he reaches from the analysis of figures in his table 6 are untenable. The table deals with the leading 10 among the principal defects for whites which may or may not coincide with the leading 10 principal defects for Negroes. Consequently, showing that for several of these 10 leading causes of rejection for white men there were fewer Negroes with these same defects, proves absolutely nothing unless these particular defects had rejection priority over all others. In certain defects, there is some indication of such priority and for these conditions the Negro rejection rates were much higher. This priority certainly holds with respect to educational deficiency which, for Negroes particularly, was never sharply differentiated from mental deficiency. There is also some indication that venereal diseases had some rejection priority over other defects, at least in the early part of the war. If a large number of Negroes were rejected for these conditions, it is natural to expect that for certain other defects the Negro rejection rates would have to be lower, but that would not be valid ground for assuming superior health conditions among Negroes.

To illustrate: Of each 1,000 Negroes examined, 99.8 were classified as educationally deficient, 19.0 as mentally deficient, and 14.6 as having neurological defects. Therefore, there were only 866.6 (1,000—133.4) Negroes left to be examined for all other defects. If venereal diseases also had rejection priority over other categories, they would take another 188.7—leaving only 677.9 Negroes who could be rejected for other defects as against 931.0 whites. In fact, it is quite possible that cardiovascular diseases had priority over other defects which caused rejection, in which case the number of Negroes per 1,000 examined that could have been rejected for the remaining defects would have been 635.4 as against 898.0 whites. Therefore, unless the excess of remaining rejection rates among whites exceeded that of Negroes by more than one-half of the Negro rate, it is impossible to conclude that total defect rates among Negroes were greater than among whites. This statement would hold true even if there were a rigid order of priority for the 10 principle causes of rejection.

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[14] Holland, Dorothy F., and Perrott, George St. J.: Health of the Negro, Part II. A preliminary report on a study of disabling illness in a representative sample of the Negro and white population of four cities canvassed in the national health survey, 1935–36, Milbank Memorial Fund Quarterly, pp. 16–38 (January 1938).

[15] Ibid., p. 34.

In fact, Dr. Friedman claims that approximately 60 percent of the Negro rejections for both periods A and B were for educational deficiency, mental deficiency, mental disease, and venereal disease. The corresponding rate for whites as determined from tables 3 and 4, pages 118, 119 of the Medical Statistics Bulletin No. 3 of the Selective Service was 28 percent. In other words, of 1,000 examined only 400 Negroes as against 720 whites could have been found with the remaining disease categories. This fact would suggest that comparative rates for these other defects could not indicate lower Negro rates unless the proportions were 2 to 1 in favor of Negroes in the sort of comparison which Dr. Friedman presents.

There are other limitations in the statistics which Dr. Friedman gives in his table 6. For instance, the differentiation between the categories of educational deficiency, mental deficiency, mental disease, and to a lesser extent neurological disorders was not always sharply drawn in the Selective Service data.

It is obvious, therefore, that Dr. Friedman's conclusions from his table 6 are invalid. The evidence cited in his table 7 would have been valid to substantiate his position, if the statistics were not deficient in certain respects for his type of analysis.

Presumably table 7 of Dr. Friedman's statement shows the defect rates for all the whites and Negroes who were called for examination under the Selective Service and Training Act. It is apparently free from the deficiencies which have been pointed out in his table 6. But when the basic data from which this table was compiled are analyzed, it becomes apparent that the defect rates for Negroes and whites are actually not comparable. Table 2 on page 9 of Medical Statistics Bulletin No. 3 shows that for the period September 1942 to June 1943 the rejection rates at local boards for whites and Negroes were 62 and 165 per 1,000, respectively. During this period, local board examinations consisted merely of screening processes which disqualified persons with obvious defects including educational deficiency. Especially, at the local boards, educational deficiency was rarely differentiated with clarity from mental deficiency. It is apparent, therefore, that for those who were rejected by preliminary screening at the local board level, only one defect was recorded, although several defects may have been present.

Medical Statistics Bulletin No. 2 of the Selective Service System shows that in the period from November 1940 through September 1941, when the local board examinations were more extensive, the number of defects per person examined averaged 1.58.[16] Medical Statistics Bulletin No. 1 shows 1.4 defects per person examined at local boards. It also indicates that excluding persons without recorded defects gives an average of 1.9 defects per person with at least one recorded defect.[17] Thirty-one percent had three defects. On the basis of this and other evidence, it is known that many physical and mental defects are correlated. It would, therefore, be reasonable to assume that the 62 whites and 165 Negroes rejected per 1,000 after inspection at local boards had, on the average, at least 2 or perhaps 3 defects. On this assumption, the over-all defect rates given in table 7 of Dr. Friedman's testimony should be increased at least to 1,071 for whites and 1,118 for Negroes and more probably something like 1,133 and 1,283 for whites and Negroes, respectively.[18] This would necessarily mean a greater increase in proportion of Negro defects, reversing the differentials for most defects. It is apparent, therefore, that Dr. Friedman's conclusions on the basis of his table 7 are also untenable.

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[16] For this average every defect was recorded, subject only to the limitation that within each of the 28 broad groups of defects (for example, eyes, ears, teeth, etc.) only 1 defect was tabulated for any one man.

[17] A maximum of three defects was tabulated per man.

[18] Note that these defect rates per 1,000 persons examined are still significantly lower than the rate of 1,357 given in the Medical Statistics Bulletin No. 1 of the Selective Service System, and the rate of 1,583 in Bulletin No. 2.

The higher rejection rate for Negroes, interpreted in view of other data showing substantially higher morbidity and mortality rates among Negroes, and less adequate medical attention, and more frequent absence of attendance in last illness justifies the inference that the higher rate must be attributable to the more deficient medical services available to our Negro population. Dr. Friedman's analysis, on the other hand, merely indicates an inappropriate use of statistics which do not lend themselves to the type of analysis to which he has subjected them.

It is not clear what Dr. Friedman is trying to establish by his table 8. One thing is apparent from his table 8 that especially for Negroes there was no sharp demarcation between mental disease and educational deficiency—a fact to which attention was called earlier. Other than that, Dr. Friedman himself calls attention to the fact that "the high incidence of syphilis and educational deficiency among the Negroes were not the only factors contributing to the high rejection rate in the Southern States. These very same two disqualifying conditions contributed heavily to the high rejection rates among the southern white registrants." There is not much to be added to that conclusion.

Table 8 in the Friedman statement, to the extent that it shows somewhat higher rejection rates for the South, corroborates more pertinent evidence based on the rejection rates by occupation which indicate a higher rejection rate for rural than urban groups.

THE DISTRIBUTION OF MEDICAL FACILITIES

Dr. Friedman refers to an "alleged maldistribution of medical facilities" but never actually states that such maldistribution does not exist, leaving it to be inferred. The stage for his remarks is set by his misinterpretation of the Lee-Jones estimates.

Dr. Friedman says: "In order to give full time employment to physicians who would furnish the high standards of care set by the Lee-Jones investigation, there should be about 1 practicing physician for every 1,200 people." The Lee-Jones report states, however, that the 1 to 1,200 ratio covers only diagnosis and treatment of disease.[19] It excludes the care of pregnancy and preventive services for the individual. The over-all ratio should be 1 to 706, or 1 to 742 if refractions are omitted.

TABLE E.—*Number of physicians required to meet the present need for individual preventive services, the puerperal state, and the diagnosis and treatment of diseases and defects*

Type of service	Physician-hours per 100,000 population (1)	Physicians required [1] Per 100,000 (2)	Physicians required [1] Persons per physician [2] (3)
Preventive services for the individual [3]	75, 373	37. 69	
The puerperal state:			
Prenatal	8, 611	4. 31	
Delivery and postpartum	18, 660	9. 33	
Total	27, 271	13. 64	
Diagnosis and treatment	166, 777	83. 38	1, 199
Total prevention, diagnosis, and treatment	269, 421	134. 71	742
Refraction	13, 710	6. 86	

[1] On the basis of 2,000 hours of service per physician.
[2] This column is the reciprocal of column 2. It does not appear in the original table.
[3] These refer to health examinations by a general medical practitioner at regular intervals. (Lee-Jones, pp. 133–134.)

Source: Lee, R. I. and Jones, L. W. The Fundamentals of Good Medical Care, Chicago, 1933, table 7, p. 115.

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[19] Lee, Roger I. and Jones, Lewis W.: The Fundamentals of Good Medical Care, Chicago, University of Chicago Press, 1933, table 7, p. 115.

In 1940, as shown in the following table, at least 40 States had less than 1 physician to 742 persons, instead of the 4 substandard States cited by Dr. Friedman.

TABLE F.—*Persons per physician in the 48 States, 1940* [1]

Alabama	1,509	Nevada	797
Arizona	1,073	New Hampshire	831
Arkansas	1,188	New Jersey	755
California	696	New Mexico	1,503
Colorado	656	New York	525
Connecticut	720	North Carolina	1,393
Delaware	840	North Dakota	1,326
Florida	1,057	Ohio	788
Georgia	1,213	Oklahoma	1,087
Idaho	1,389	Oregon	836
Illinois	690	Pennsylvania	775
Indiana	887	Rhode Island	813
Iowa	877	South Carolina	1,504
Kansas	958	South Dakota	1,416
Kentucky	1,112	Tennessee	1,086
Louisiana	1,034	Texas	1,012
Maine	948	Utah	1,038
Maryland	687	Vermont	746
Massachusetts	593	Virginia	1,076
Michigan	872	Washington	923
Minnesota	851	West Virginia	1,093
Mississippi	1,606	Wisconsin	947
Missouri	771	Wyoming	1,195
Montana	480		
Nebraska	865	Total United States	820

[1] Based on the number of active non-Federal physicians.

Source: U. S. Public Health Service, unpublished data based on the 1940 American Medical Directory.

Dr. Friedman is correct in stating that the county is a poor unit for measuring the adequacy of medical facilities. Most investigators have employed it only for want of better data. Four years ago it was said in a Public Health Service report: [20]

"* * * when small geographical units are considered, particularly in or adjacent to metropolitan centers, serious error is likely to be introduced by the flow of patients into or out of the area * * *. It is true that the magnitude of the correction cannot be determined for a specific area without special study, but at least the existence of such an error should be recognized. If it were feasible, it would often be desirable to deal in terms of medical trade areas instead of political units."

The Public Health Service has made a start in this direction by dividing the country into health-service areas consisting of groups of counties, and published this study in 1945.[21] Relatively few of these areas have the desired ratio of physicians to population.

That the number of physicians in rural areas is inadequate is well known. While counties may not be good units for study, States certainly are. Table F shows that a rural State like Arkansas had only 1 physician to 1,188 persons, as compared with 1 to 720 in an urban State such as Connecticut. The situation with respect to dentists is much worse. Moreover, numerical ratios of medical personnel to population give no clue to such factors as the older average age of rural physicians, the heavy concentration of specialists in certain States and cities, and the great concentration of physicians and dentists in the areas of greatest income.

On page 12 of the Friedman statement it is claimed that, "according to Falk, Klem, and Sinai (11, p. 90), 77 percent of the population living on farms and rural communities are within reasonable access to hospitals." Actually, the quoted statement refers only to the surveyed group, thus:

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[20] Ciocco, A., Davis, B. M., and Altman, I.: Measures of medical resources and requirements, Medical Care, 3: 315 (November 1943).

[21] U. S. Public Health Service: Health Service Areas, Public Health Bulletin No. 292, Washington, Government Printing Office, 1945.

"* * * of the 8,758 families surveyed, 3,208 reside in rural areas or in towns with less than 5.000 persons. Of this group, 77 percent live in places which are within reasonable access of hospitals; but 23 percent are more remote from hospitals. Where there are no hospitals, other facilities and agencies are also ordinarily lacking or limited in number, kind, and competence." [22]

Therefore, it is apparent that the figures in this study actually underestimate the problem.

From the fact that rural hospitals often show low bed-occupancy rates, Dr. Friedman apparently infers a lack of real need. There are, however, excellent reasons why the areas with the fewest hospital beds have the lowest occupancy rates. The answer is to be found in the lack of effective economic purchasing power in these areas, rather than in any lack of actual need for hospital care. States with low hospital-occupancy rates have the lowest per capita incomes; average per capita payments for hospital care are smallest; and hospitals in these States receive proportionately more of their income from patients' fees and less from tax funds and philanthropic contributions.

As was said in a Public Health Service report:

"If operation of hospitals is mainly dependent upon fees paid by patients, opportunities for treatment are limited not only among indigent persons but also among the marginal income classes that are not on relief but are unable to purchase hospital care after essentials of life had been procured. As taxation becomes an important means of support, possibilities become greater that those of straitened circumstances, as well as their more prosperous neighbors, may obtain hospital care. As wealth decreases from one income class of States to another, the proportion of hospital income obtained directly from patients increases; concomitantly, the relative amounts from taxes and miscellaneous sources diminish." [23]

Many of the low-occupancy hospitals, moreover, are small, and as shown in the following table, occupancy ratios in small hospitals are generally less than in large hospitals. Many are proprietary and hence give little, if any free care; admission to such hospitals is often restricted to the patients of the doctors who own the hospital. The average number of days of care received is small.[24] As Senate Committee Print No. 4 pointed out (p. 22), "in 1944 people in New York State received * * * 1.4 days (of care in general hospitals) per person. Mississippians, on the other hand, received * * * only 0.38 days per person."

TABLE G.—*Average daily census per 100 beds, in registered hospitals, by size and control, 1936* [1]

Size of hospital	All hospitals	Non-profit	Proprietary	Federal	Other governmental
All hospitals	65	63	45	69	79
Very small (under 25 beds)	45	64	38	80	44
Small (25–49 beds)	51	56	42	62	51
Medium (50–149 beds)	58	60	49	62	57
Large (150 beds and over)	72	65	58	70	85

[1] Based on 4,635 hospitals reporting usable data on bed capacity, average daily census, and type of control.

Source: Mountin, Joseph W. Pennell, Elliott H., and Flook, Evelyn: "Selected characteristics of hospital facilities in 1936," in Hospital Facilities in the United States, Washington, Government Printing Office, 1938. (Public Health Bulletin No. 243).

While it may be true that the percentage of persons seeing a physician is almost as high in rural areas as in the largest cities, the number of visits per person is higher in the more urban areas. Regardless of the number of times a person visits his doctor, he is counted just once in the over-all percentage of persons seeing a physician. On the other hand, the number of visits per person takes into account, obviously, the frequency with which the physician is seen, and thus provides a better measure of the volume of physicians' services. It will be observed in table H that calls by a physician per 1,000 persons were: Cities of 100,000 and over, 2,420; cities of 5,000 to 100,000, 2,233; and towns under 5,000 and rural areas, 1,750.

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[22] Falk, I. S., Klem, Margaret C., and Sinai, Nathan: The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families (CCMC, Publication No. 26), Chicago, University of Chicago Press, 1933, p. 90.

[23] See Pennell, Mountin, and Pearson: Existence and Use of Hospital Facilities Among the Several States in Relation to Wealth as Expressed by Per Capita Income, Public Health Reports, 55; 822–846 (May 10, 1940). Reprint No. 2160.

[24] Ibid.

TABLE H.—*Services of physicians and other practitioners in connection with illness in cities of different sizes—7,434 canvassed white families in 14 States,[1] 1928–31*

Type of rate	All cities sizes [1] (simple means of rates in the three sizes)	Annual rates per 1,000 population [2]		
		Cities of 100,000 or over	Cities 5,000 to 100,000	Towns under 5,000 and rural areas
Total illnesses [3] per 1,000 population	830	795	846	850
Calls [4] per 1,000 population:				
Calls by any practitioner	2, 641	3, 003	2, 679	2, 240
Calls by all private physicians and specialists	2, 134	2, 420	2, 233	1, 750
Home calls by private general physicians	1, 063	1, 192	1, 168	829
Clinic calls [4]	311	362	245	325
Calls by nonmedical practitioners	196	221	201	165
Calls by all practitioners per total case	3. 18	3. 78	3. 17	2. 64
Population under observation	32, 686	11, 593	8, 550	12, 543

[1] The families surveyed in Massachusetts, Connecticut, Colorado, and Washington State are not included.

[2] These rates (*a*) are built up from individual summary cards without allowance for occasional cases with an unknown number of calls; (*b*) are not adjusted for age; (*c*) are not based on all of the canvassed families; and (*d*) the rates for cities of all sizes are simple means of the rates in the 3 city-size classes.

[3] All illness, both attended and not attended by doctors.

[4] Calls in connection with illness, except that clinic care includes also calls for immunization, well-baby care, and health (including school) examination.

Source: Collins, Selwyn D., Public Health Reports, 55: 1977–2020 (Nov. 1, 1940) table 2.

As for inoculations, the most frequent services are smallpox vaccinations and diphtheria immunizations. As shown in table I, the CCMC found the vaccination rate to be markedly lower in the rural areas—less than half that for cities over 100,000.

TABLE I.—*History of smallpox vaccinations among persons in cities of various sizes and in rural areas—Canvassed white families in 18 States* [1]

Age in years	Percentage of persons with a history of—								Total number of persons considered			
	Vaccination or case at any time				Vaccination at any time but no case							
	Cities of 100,000 or over	Cities 5,000 to 100,000	Towns under 5,000	Rural areas	Cities of 100,000 or over	Cities 5,000 to 100,000	Towns under 5,000	Rural areas	Cities of 100,000 or over	Cities 5,000 to 100,000	Towns under 5,000	Rural areas
All ages	73. 0	54. 0	49. 3	38. 5	71. 5	50. 5	45. 0	34. 2	14, 089	9, 531	7, 442	6, 797
Under 2	8. 1	3. 7	6. 0	1. 9	8. 1	3. 5	6. 0	1. 9	677	537	331	263
2 to 3	19. 3	9. 6	10. 5	5. 8	18. 9	9. 1	10. 3	5. 8	747	584	448	347
4 to 5	37. 1	22. 9	15. 5	12. 7	36. 7	22. 4	15. 3	11. 5	758	639	503	404
6 to 7	75. 4	49. 3	37. 2	26. 6	74. 6	48. 6	35. 9	25. 5	838	586	523	381
8 to 9	81. 7	58. 7	45. 3	34. 4	80. 9	56. 7	42. 7	33. 0	772	589	424	426
10 to 14	85. 0	66. 5	54. 7	45. 7	84. 0	64. 0	50. 5	41. 6	1, 577	1, 105	907	976
15 to 19	86. 1	67. 5	63. 3	48. 2	84. 9	64. 2	56. 4	42. 0	1, 035	757	568	681
20 to 24	87. 2	65. 4	63. 1	46. 3	85. 6	60. 2	57. 3	40. 0	863	504	360	383
25 to 34	82. 7	62. 5	62. 7	47. 9	80. 5	55. 9	57. 8	43. 6	2, 362	1, 428	1, 094	742
35 to 44	82. 2	67. 1	61. 8	45. 5	79. 9	61. 5	54. 8	39. 5	2, 305	1, 509	1, 134	979
45 to 54	83. 4	63. 8	57. 5	45. 7	80. 9	59. 4	50. 5	38. 9	1, 248	803	629	673
55 and over	74. 9	60. 5	60. 2	42. 9	72. 9	56. 8	56. 0	36. 6	907	490	521	542

[1] Dates of interviews varied from 1928 to 1931. Data refer to histories at the beginning of the 12-month morbidity study.

Source: Collins, Selwyn D., Public Health Reports, 51:443–479, Apr. 17, 1936, table 2.

The rural areas, however, show a higher rate of diphtheria immunization.[25] Physical examinations, curiously enough, were most frequent in towns under 5,000 (89.3 per 1,000 population), but least frequent in rural areas (52.6). (See table J). In the table shown by Dr. Friedman, these two are combined.

TABLE J.—*Physical examinations per 1,000 persons in urban and rural communities—Canvassed white families in 18 States during 12 consecutive months, 1928–31 (all types of examinations)*

Population of city or town	All ages [1]		Under 5		5 to 19		20–44	45 and over
	Including infant and child supervision	Excluding infant and child supervision	Including infant and child supervision	Excluding infant and child supervision	Including infant and child supervision	Excluding infant and child supervision		
	Examinations per 1,000 population per year							
Cities of 100,000 or over	90.7	65.8	235.4	56.0	109.6	108.3	41.2	46.9
Cities of 5,000 but under 100,000	93.5	59.7	232.6	42.3	84.0	73.6	37.7	103.2
Towns under 5,000	113.6	89.3	223.1	78.4	187.1	179.2	31.3	21.7
Rural areas	62.5	52.6	135.1	60.2	92.3	91.6	23.7	13.1
	Number of examinations							
Cities of 100,000 or over	1,302	944	462	110	505	499	228	101
Cities of 5,000 but under 100,000	906	579	357	65	284	249	130	134
Towns under 5,000	862	677	253	89	501	480	81	25
Rural areas	432	364	119	53	246	244	50	16
	Population (years of life)							
Cities of 100,000 or over	14,351		1,963		4,609		5,540	2,155
Cities of 5,000 but under 100,000	9,694		1,535		3,381		3,449	1,298
Towns under 5,000	7,585		1,134		2,678		2,589	1,151
Rural areas	6,914		881		2,665		2,111	1,218

[1] "All ages" includes a few of unknown age.

Source: Collins, Selwyn D., Public Health Reports, 49:321–346, Mar. 9, 1934, table 7.

Despite Dr. Friedman's inference that serious maldistribution of medical facilities does not exist in this country, a vast accumulation of evidence exists to the contrary, of which the above-mentioned data are merely examples. The voluminous hearings held on the Hill-Burton Hospital Survey and Construction Act, the detailed documentation of needs furnished in such publications as Senate Committee Print No. 4, and the Department of Agriculture's booklet Better Health for Rural America, and the current series of reports on communities needing physicians appearing in the Journal of the American Medical Association, all indicate the extensive nature of the problem.

THE ECONOMIC BARRIER TO ADEQUATE MEDICAL CARE

Dr. Friedman's statement under this heading seems to infer that, since 47 percent of the people surveyed by the CCMC had no illness in a year and only 9.8 percent reported illness but received no care, the statement that 40 percent of the population lacked needed medical services is invalid. He therefore concludes that the importance of the economic barrier to adequate medical care has been greatly exaggerated. In drawing his conclusion from these figures, Dr. Friedman has neglected to consider several important additional facts.

In the first place, the over-all average of 40 percent of the population that received no care of any kind during the study year conceals the relation of economic status to the receipt of care. In the income group below $1,200, 47 percent of the family members reported no medical, dental, or eye care, a figure that may be contrasted with only 14 percent in the highest income group who reported no such care. Three conclusions may be drawn: (1) That economic standing is of little significance and the poor are healthier and require less medical attention than the well-to-do; (2) that there is an excessive demand for medical care among high-income groups; or (3) that many persons among the lowest-income groups fail to receive needed care. That this last is the logical and correct assumption is suggested by the overwhelming body of evidence and general experience.

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[25] Collins, Selwyn D.: History and Frequency of Diphtheria Immunization. Public Health Reports, 51: 1736–1773 (Dec. 18, 1936), table 7, Reprint 1789.

Aside from the question of the proportionate number of persons in the low- and high-income levels who receive medical care, some type of medical service is needed by nearly everyone in the population, regardless of financial standing. What of preventive measures to assure good health? Medical authorities consistently advocate annual health examinations for all individuals. The Lee-Jones study recommended that out of each 1,000 persons, 942 should receive a yearly health examination. Consider also that dental care was one of the services which 40 percent of the surveyed population failed to get. The Lee-Jones study concluded that all persons 3 years of age and over should receive some dental care each year. Yet 47 percent of the people with family incomes under $1.200 had no health examinations, no immunizations, and no dental examinations or prophylactic services. The lack of care is even greater than these figures indicate because—as the original study points out—"those who bought drugs and medicines as their only form of medical care are counted as persons who received some medical attention. If correction could have been made for these individuals, the percentage of persons in each income class or in all combined who had no medical care would be considerably larger than the figures show." [26]

The contrast between the lowest and highest income classes is likewise concealed in the finding that 9.8 percent of the persons studied by the CCMC recognized and reported some illness but received no care during the year. At the lowest family income scale, 14 percent of the persons reported illness but received no care, as compared with only 4 percent at the highest level. In the group that reported illness and the receipt of some care—43 percent of all persons surveyed—the proportion varied from 38 percent in the lowest income group to 58 percent in the highest. These comparisons, however, give only a crude indication of the difference in extent to which persons in various income classes receive care. A person who reported illness was counted as receiving care if he received only one unit of service during the study year (for example, one office call), regardless of the number of illnesses he may have had. These figures give no indication of the extent to which individual illnesses were or were not attended and the amount of care received for each.

Moreover, evidence from public-opinion polls further substantiates the conclusion that lack of funds to pay for medical care raises a barrier to the receipt of needed care. In a poll conducted in 1944 for the National Physicians' Committee for the Extension of Medical Service (a group of physicians opposing compulsory national health insurance), 29 percent of the persons who were asked, "Have you ever put off going to a doctor because of cost?" replied, "Yes." In a second poll conducted for the same committee in 1945, 40 percent of the persons interviewed answered "Yes" to the question, "Do you know of anyone who has gone without doctor or hospital care because he or she could not afford it?"

Finally, among the people who report no illness during a year there are symptoms which are not recognizable by lay persons, but require physicians' services to determine "illness" and the need for medical care. As a physician, Dr. Friedman can undoubtedly point to numerous cases in his own experience when physical examinations of ostensibly "healthy" individuals have revealed conditions requiring immediate and perhaps extensive medical service. As an example of the existence of unknown conditions, experts in the tuberculosis field estimate that there are more than 500,000 cases of active disease at the present time, of which 250,000 to 300,000 are known. Thus, about one-fourth of a million people are going about their every-day activities, unaware that they have active tuberculosis! Many people who have cancer and heart disease, to mention only two other diseases, are unaware of their ailments even in advanced stages. Unquestionably, the CCMC finding that 47 percent of the persons surveyed reported no illness gives an exaggerated picture of the "good health" of the population.

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[26] Falk, I. S., Klem, Margaret C., and Sinai, Nathan: The Incidence of Illness and the Receipt and Cost of Medical Care Among Representative Families (CCMC, Publication No. 26), University of Chicago Press, 1933, pp. 102, 103.

Many studies illustrate the differences in the receipt of care by high- and low-income families. A survey of families in the petroleum-producing area of Arkansas showed that 14.5 percent of the illnesses in families with less than $250 annual income received physicians' care, as contrasted with 38.9 percent in families with incomes of $2,000 or more. Each of the attended illnesses in the lowest income class received an average of 5.4 home and office calls from the physician, while those in the $2,000 and over group received an average of 10.9 calls. There were, on the average, 60.5 days of illness per family and 15.5 per person in the lowest income class as contrasted with 47.2 per family and 11.8 per person in the highest.[27]

According to the CCMC survey, in the lowest income families there were some 800 reported actual illnesses per year per 1,000 persons and, on the average, about 2 home, office, or clinic visits per person for the receipt of physicians' service. Among the families with the highest income, on the other hand, the illness rate was slightly more than 1,000 per 1,000 persons, and each person had an average of 5 visits to or by physicians.[28]

The National Health Survey of 1935–36 likewise gave evidence that, as family income rises, there is a general tendency toward an increase in the number of cases of illnesses that are medically attended. In the lower income group (especially the relief families), the amount of care per patient treated by doctors was below that in the higher group, as shown in table **K**.

TABLE K.—*Percent of disabling illnesses receiving doctor's care and doctor's calls per case of disabling illness receiving care*

Family income	Percent of disabling illness receiving doctor's care	Doctor's calls per case of disabling illness receiving care
All incomes	81	7.4
Relief	78	6.8
Nonrelief:		
Under $1,000	78	7.9
$1,000 to $2,000	82	7.2
$2,000 to $3,000	85	7.6
$3,000 to $5,000	87	8.0
5,000 and over	89	9.2

Source: Britten, Rollo H.: The National Health Survey: Receipt of Medical Services in Different Urban Population Groups, Public Health Reports, 55:2199–2224, Nov. 29, 1941, pp. 2208, 2210.

A study of medical care among families in California in 1934 indicated that the proportion of illnesses receiving any care increased from 68 percent in the relief group to 78 percent in the group with incomes of $3,000 or more. The proportion receiving physicians' care increased from 58 percent to 71 percent from the lowest to the highest income levels.[29]

The American Medical Association has admitted that low income is a barrier to medical care.[30] On the basis of the income set by that association as the minimum needed if a family is to finance adequate medical care through its own resources, some 70 percent of the population of the United States may need assistance in paying for medical care.

Dr. Friedman asserts, incidentally, that the proponents of compulsory health insurance "deny that the services rendered gratis by the members of the medical profession are of any considerable significance." The basis for his information is not known. The major studies of the receipt and costs of medical care have included considerable information on the medical services of all types which were provided to the surveyed population free of charge as well as for fees. The Falk, Klem, Sinai study, to which Dr. Friedman makes frequent reference, recorded that "The percentage of individuals who receive only free care declines from 8.2 percent in the lowest to 0.3 percent in the highest income class."[31] In the Consumer Purchases study from which Dr. Friedman also quotes, a record of the families receiving free medical care during the study year was likewise included.

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[27] Wilson, Isabella C.: Sickness and Medical Care Among the Rural Population in a Petroleum-Producing Area of Arkansas (1938) Bull. No. 413, University of Arkansas, Agricultural Experiment Station, June 1941, p. 23.

[28] Falk, Klem, Sinai: op. cit., pp. 110, 283.

[29] Klem, Margaret C.: Medical Care and Costs in California Families in Relation to Economic Status (1933–34). San Francisco, State relief administration, 1935 (processed), p. 84.

[30] American Medical Association, Bureau of Medical Economics: Factual Data on Medical Economics, Chicago, revised 1940, pp. 90–91.

THE INCIDENCE OF ILLNESS

While the findings of the CCMC indicated that illness occurred with much the same frequency among rich and poor, a study of other sources shows significantly higher morbidity among the poor. The explanation for the higher frequency of reported illness among the high-income CCMC families, compared with those who had lower incomes, is well known among persons familiar with sickness surveys. The surveyed families extended into somewhat higher income groups than did families in other illness studies, included a smaller proportion of the very poor, and the very poor were merged into a broad group (about 15 percent of the total population) who were in the income group "under $1,200." As Dr. Friedman himself points out, "It is quite possible that the reported incidence of illness would be higher in the more prosperous groups even if the true incidence were the same (or lower) than in the lower income groups. However, this would be more likely to be true of relatively minor illnesses." In the CCMC study, families were interviewed at intervals of 2–4 months, whereas in most other surveys the family illness record for the specified period (usually a year) was obtained in one visit. It is quite likely that minor illnesses would be more completely represented in the CCMC data, particularly in the high-income families whose members could afford to recognize such illnesses and receive medical care for even minor conditions. When the CCMC data are examined in terms of severity of illness—as, for example, days of disability, rather than the number of reported illnesses—a distinct difference between low and high-income levels is found (see table L).

As was pointed out in 1936:

"While the annual number of disabling cases per person shows no significant variation with income, the total days of disability per person and per case of disabling illness in the lowest income group is over twice that in the highest. In the lowest income group, 50 percent of the disabling cases were of 8 days' duration or less, 30 percent were between 9 and 24 days, and 20 percent were 25 days or more: the corresponding values for the highest income group were 63, 26, and 11 percent respectively."[32]

TABLE L.—*Disability rates of wage earners, by family income*

Annual family income	Annual rate		
	Disabling cases per person [1]	Days of disability	
		Per person	Per disabling case
Under $1,200	0.36	8.9	24.7
$1,200–$1,999	.37	5.7	15.4
$2,000–$2,999	.36	5.0	13.9
$3,000 and over	.34	3.8	11.2

[1] Wage earners, ages 15–64, both sexes, exclusive of farmers and farm laborers, professional persons, proprietors, managers, and officials.

Source: Perrott, G. St. J.: The State of the Nation's Health. The Annals of the American Academy of Political and Social Science, 88:131–143 (November 1936), table IV.

The National Health Survey also showed the frequency of both acute and chronic illness to be highest in the families on relief. This fact is clear from table M; for example, the rate for all illnesses was over 50 percent higher in the relief group than it was in the groups with incomes of more than $1,500. The data on chronic disease are particularly important. The National Health Survey found that for chronic disease "The average number of days lost per person is almost three times as great among families on relief as among families with incomes of $3,000 or over, and twice as great among nonrelief families with incomes under $1,000." [33]

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[31] Falk, Klem, and Sinai: op. cit., p. 168.

[32] Perrott, G. St. J.: The State of the Nation's Health, The Annals of the American Academy of Political and Social Science, 88: 131–143 (November 1936).

TABLE M.—*Annual frequency of acute and chronic illnesses disabling for 1 week or longer (per 1,000 persons) as related to economic status*

Annual family income and relief status	All illnesses	Acute	Chronic
All incomes	171	123	48
Relief	232	160	72
Nonrelief:			
Under $1,000	176	120	56
$1,000 to $1,500	155	117	38
$1,500 to $2,000	146	111	35
$2,000 to $3,000	145	110	36
$3,000 to $5,000	145	109	36
$5,000 and over	146	107	39
Relief and nonrelief under $1,000	200	138	63

Source: Britten, R. H., Collins, S. D., and Fitzgerald, J. S.: The National Health Survey—Some general Findings as to Disease, Accidents, and Impairments in Urban Areas, Public Health Reports, 55: 444–470 (Mar. 15, 1940), table 5.

Collins in 1927 assembled several earlier studies, all of which demonstrated that "the cases of sickness per 1,000 persons * * * increase as economic well-being goes down." [34] The findings of two of these studies are shown as tables N and O. The same was true of the Health and Depression Studies: "The general result is clearly shown, by surveys of samples of the poorer sections of eight large cities, that wage-earning families reduced to poverty during the depression suffered to a greater extent from disabling illness in 1933 than their more fortunate neighbors. Individuals in families supported by public or private relief exhibited a higher illness rate than any other group. This finding was true for children as well as for adults and in general for respiratory and nonrespiratory illnesses, with the exception of the communicable diseases of childhood. Whatever the implications of the results, the fact remains that illness was most prevalent among those who could least afford this handicap." [35]

Tables N and O give further evidence of the effect of income on disability.

TABLE N.—*Sickness prevalence in Hagerstown, Md., by estimated economic status of the households*

[Cases of sickness per 1,000 persons as ascertained by a canvass of 1,751 white households in November 1921]

Economic status	Cases of sickness per 1,000 persons	Percent of households having cases of sickness	Number included in survey	
			Persons	Households
Well-to-do and comfortable	32.2	10.3	808	213
Moderate	37.6	12.3	3,400	829
Poor and very poor	40.1	16.9	3,316	709

Source: Collins, Selwyn D.: Economic Status and Health, Public Health Bulletin No. 165, Washington, Government Printing Office, 1927, table I.

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[33] National Health Survey preliminary reports, Sickness and Medical Care Series, Bulletin No. 6, The Magnitude of the Chronic Disease Problem in the United States. 1938.

[34] Collins, Selwyn D.: Economic Status and Health, Public Health Bulletin No. 165, Washington, Government Printing Office, 1927, p. 5.

[35] Perrott, G. St. J., and Collins, Selwyn D.: Relation of Sickness to Income and Income Change in 10 Surveyed Communities, Public Health Reports, 50: 595–622 (May 3, 1935), Reprint 1684.

TABLE O.—*Sickness prevalence and days lost from work by family income per adult male unit, 1916*

[Cases of disabling sickness per 1,000 persons as ascertained by canvass of 4,161 white persons and the percent of total possible workdays lost from disability by 1,541 wage-earning members of families in 7 cotton-mill villages of South Carolina]

Half-month family income per adult male unit	Sickness prevalence May–June 1916		Days lost from work January–May 1916	
	Case rates per 1,000 persons canvassed	Number of persons canvassed	Percent of total possible working days which were lost from disability	Average number of wage-earning persons observed per month
Less than $6	70.1	1,312	5.9	395
$6 to $7.99	48.2	1,038	3.6	349
$8 to $9.99	34.4	784	2.6	306
$10 and over	18.5	1,027	2.3	491

Source: Collins, Selwyn D.: Economic Status and Health, Public Health Bulletin No. 165, Government Printing Office, Washington, 1927, table II.

The "conflict" between the data in the two studies (CCMC and National Health Survey) to which Dr. Friedman refers is thus more apparent than real. When the data from both studies are carefully analyzed, it is clear that disability was greater in the lower-income groups.

In his attempt to refute findings of the National Health Survey, Dr. Friedman lifts several statements from their context without citing other information given elsewhere in the reports of that survey.

He says, for example, "In the first place the information was gathered by untrained workers enlisted from relief rolls * * *." But the report also indicated that the enumerators were mature persons with previous white-collar experience. "Preference was given to those people who had been bookkeepers, teachers, nurses, salesmen, and social workers. Many had had experience in other surveys. Final selection was made on the basis of aptitude tests." Moreover, the enumerators received careful training and were always under expert supervision. All schedules were carefully reviewed.

Dr. Friedman seems to imply that, since the diagnoses of illnesses given by the persons interviewed were confirmed by physicians in only 26 percent of all illnesses and in only 35 percent of chronic illnesses, the unconfirmed diagnoses were wrong. The source reference, however, shows that when the statements from the family and from the physician could be compared, an agreement of about 90 percent was found in terms of classifications of diagnoses into 15 to 30 groups.

Dr. Friedman takes exception to the fact that the National Health Survey made adjustments for age. He surely knows that the adjustment of rates is a standard and necessary procedure to make groups comparable. The methods are described in all texts on vital statistics or biometry. Moreover, his reference 32—the pertinent part of which is here included as table P—gives not only the adjusted rates but the so-called crude rates as well. They do not differ greatly; in fact, the differences between low and high-income groups are even greater in the unadjusted data.

TABLE P.—*Annual frequency of pneumonia per 1,000 white persons observed, according to economic status*

[Frequency per 1,000 persons observed]

Annual family income and relief status	All ages	
	Crude	Adjusted [1]
All known	5.4	5.4
Relief	8.8	8.3
Nonrelief:		
Under $1,000	5.5	5.3
$1,000 to $1,500	4.8	4.8
Nonrelief—Continued.		
$1,500 to $2,000	4.3	4.5
$2,000 to $3,000	4.2	4.5
$3,000 to $5,000	4.2	4.6
$5,000 and over	4.1	4.2

[1] Adjusted to the age composition of all white persons enumerated in the National Health Survey.

Source: Perrott, G. St. J., Tibbitts, C., and Britten, R. H.: The National Health Survey—Scope and Method of the Nation-wide Canvass of Sickness in Relation to Its Social and Economic Setting, Public Health Reports, 54:1663–1687 (Sept. 15, 1939).

Dr. Friedman's charge that adjustment is "manipulation" is difficult to understand, since he criticizes the lack of age adjustment a few pages earlier.

Again from Friedman's statement:

"Adjustments were also made for those diseases with high death rates (heart disease, cancer, arteriosclerosis, etc.) to avoid undernumeration. This was done by obtaining a correction ratio from the death rate in the United States in 1935 as furnished by the Bureau of the Census."

This adjustment was not made, however, in any of the data that Dr. Friedman cites; e. g., when he discusses all types of acute and chronic illness.

THE VOLUME AND DISTRIBUTION OF MEDICAL SERVICES UNDER THE PRESENT SYSTEM

It is true, as Dr. Friedman states, that "there is no steady rise of volume of services with each rise in income and the various services do not rise in parallel with a rising income." The CCMC report carefully points out, however, that "* * * the difference between the effective demand for medical care and the true need for the preservation of health and for care in sickness is in general correlated with family income," and that "* * * there are comparatively regular variations (in the amount of medical care received) associated with economic circumstance."[36]

It has not been possible to find in any of the CCMC studies a statement cited by Dr. Friedman that "the rise in volume (of medical care) with rise in income should be approximately the same for all kinds of medical care." Such a situation would not be expected and was not found to be true. Table Q, taken from the CCMC report No. 26, shows the relation of the volume of medical care received to income. In general, when the care was of a nonemergency character and depended in the main on the choice of the patient, the percentage of persons receiving service increased steadily as economic barriers grew less.

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[36] Falk, I. S., Klem, Margaret C., and Sinai, Nathan: The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families (CCMC Publication No. 26), Chicago, University of Chicago Press, 1933, pp. 140, 240.

TABLE Q.—*Family income and care received per 1,000 persons—Medical care for illness and medical cases among 38,668 white persons in 8,639 families with known income, surveyed for 12 consecutive months, 1928–31* [1]

Illness or unit of service	Service per 1,000 persons in families with specified income						
	Under $1,200	$1,200 to $2,000	$2,000 to $3,000	$3,000 to $5,000	$5,000 to $10,000	$10,000 and over	All incomes [2]
Illnesses [3]	802.5	805.0	828.9	880.4	989.7	1,111.5	844.5
Hospitalized cases (1 day or longer):							
All hospitals	59.4	52.4	59.4	63.1	79.3	98.0	60.1
General hospitals only [4]	55.6	51.2	58.5	62.0	77.8	97.2	58.6
Hospital days:							
All hospitals	1,368.7	863.9	884.0	731.2	896.0	1,270.4	937.7
General hospitals only [4]	927.9	666.7	757.4	604.2	840.3	1,200.8	745.8
Physicians:							
Home, office, and clinic calls on account of illness [5]	1,931.9	2,045.9	2,296.7	2,741.4	3,621.4	4,734.4	2,391.2
All home, office, and clinic calls [6]	2,169.2	2,268.5	2,508.9	2,995.5	3,976.7	5,321.0	2,638.8
Home calls	861.4	847.2	1,037.1	1,308.9	1,330.9	2,359.7	1,048.0
Office calls	821.0	1,110.7	1,286.2	1,524.1	2,489.9	2,918.6	1,326.3
Clinic calls	486.8	310.6	185.6	162.5	155.9	42.7	264.5
Dental cases [7]	115.4	185.7	248.4	347.1	517.1	867.2	259.7
Dental care (persons over 3 years of age)	117.9	184.6	247.5	309.4	446.0	622.0	241.1
Refractions or glasses [8]	24.5	24.6	39.6	53.8	89.6	159.7	41.5
Health examinations [9]:							
Excluding well-baby care	53.2	51.8	57.0	71.5	107.0	224.5	65.4
Including well-baby care	83.2	68.0	69.1	82.2	121.7	234.0	81.6
Immunizations [10]	68.5	49.2	50.9	59.6	84.3	120.2	58.7
Secondary and sectarian practitioners: [11]							
Home and office calls	154.6	139.1	230.4	231.1	459.0	569.2	213.4

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[1] Adjustment for 1,311 persons surveyed for less than 12 months reduces the number to 38,042 on an annual basis. This adjusted number is used in the calculation of rates.

[2] Data for all incomes are weighted for the several income classes according to the proportions in the standard (p. 28 of source).

[3] Where no illness is involved, health examinations, immunizations, and dental and eye cases are excluded. Minor nondisabling illness and well-baby care are also excluded.

[4] Includes all hospitals except tuberculosis sanatoria and mental hospitals.

[5] Where no illness is involved, health examinations, immunizations, dental and eye cases are excluded; well-baby care is also excluded, minor nondisabling illness is included.

[6] Includes all calls for illness, health examinations, immunizations, and well-baby care; excludes all calls for refractions.

[7] Each course of dental care is counted as a single case. Includes dental cases with and without illness.

[8] Includes services from physicians, oculists, optometrists, opticians. Includes all refractions whether or not accompanied by illness.

[9] Includes complete physical examinations for diagnostic purposes, regular periodic, school, entrance, insurance, and other examinations, check-up after operation, check-up of particular organ or part of body to see if treatment is needed, check-up unspecified, and examinations of communicable disease contacts.

[10] Includes service whether or not accompanied by illness.

[11] Includes osteopath, chiropractor, Christian Science practitioner, faith healer, midwife, and others of doubtful medical status.

Source: Falk, I. S.; Klem, Margaret C.; and Sinai, Nathan: The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families (CCMC, Publication No. 26), Chicago, University of Chicago Press, 1933, appendix table B–27, p. 283.

Dental care is an example of this type. It is usually of a nonemergency character and is usually costly. Receipt of dental treatment is influenced by the educational and social background of the family. It is therefore not surprising that the receipt of dental care shows a steady increase with income.

The amount of hospital care received reflects the availability of free public hospitals in urban centers, as contrasted with the fewer free beds in hospitals in rural areas. This difference accounts for the higher average number of days of hospital care in urban areas for the lowest income group. When communities of all sizes are considered, each 1,000 persons in the lowest income class received 928 days of hospital care, an amount larger than for any other income class under $10,000 or more, for which the figure was 1,201 days. In large cities, the lowest income group received 1,808 days of hospital care per 1,000 persons; in cities of 5,000 to 100,000, they received 1,129 days of care; but in towns and rural areas, they received only 695 days of hospital care. Table R shows the variation by income and size of community:

TABLE R.—*Annual hospital days per 1,000 population*

Annual family income	Cities of 100,000 or or over	Cities of 5,000 to 100,000	Towns under 5,000 and rural
Under $1,200	1,808	1,129	695
$1,200 but under $2,000	777	550	530
$2,000 but under $3,000	801	580	509
$3,000 but under $5,000	664	545	590
$5,000 and over	954	880	499

Source: Collins, Selwyn D.: Variation in Hospitalization With Size of City, Family Income, and Other Environmental Factors; Based on Records for 9,000 Families in 18 States, Visited Periodically for 12 Months, 1928–31. Public Health Reports, 57: 1635–1659 (Oct. 30, 1942), p. 1646.

Dr. Friedman asserts that "with health examinations and immunizations the highest income group received more service than the lowest, but in between the relation between income and volume of service was definitely not what would have been expected if cost were the determining factor." Probably Dr. Friedman did not know of the additional publications of Selwyn Collins, of the Public Health Service, based on the data collected by the CCMC, since they are not referred to in the bibliography. The Collins studies point out that "* * * physical examinations are considerably more frequent among the higher income groups than in the lower income classes. * * * With the exception of the lowest class, there is a constantly rising examination rate as income increases. If infant supervision is excluded, the increase with income is more marked. In the families with incomes of $5,000 or over, the total examination rate (exclusive of infant supervision) is more than 2½ times that in the lower income groups, while the examination rate in families with incomes of $10,000 or over is more than 4 times that in the groups with incomes under $2,000." [37]

In table S, which shows the difference by age and family income, the high rate in the age groups under 15 is due to the large volume of work done in public clinics.

TABLE S.—*Physical examinations per 1,000 persons in canvassed white families of different income levels in 18 States during 12 consecutive months, 1928–31 (all types of examinations)*

Annual family income	All ages		Under 5		5 to 14		15 to 24	25 to 44	45 to 64	65 and over
	Including infant and child supervision	Excluding infant and child supervision	Including infant and child supervision	Excluding infant and child supervision	Including infant and child supervision	Excluding infant and child supervision				
Under $1,200	93.8	52.2	267.2	42.6	125.1	109.9	38.7	24.9	9.2	8.1
$1,200 but under $2,000	76.8	51.3	176.9	35.2	127.4	120.3	32.1	18.2	18.3	7.1
$2,000 but under $3,000	75.9	56.7	187.6	57.7	106.5	104.9	50.5	28.4	33.3	42.3
$3,000 but under $5,000	86.3	70.7	221.8	82.7	122.5	119.9	56.6	50.3	42.0	64.3
$5,000 and over	154.6	136.7	391.6	177.5	177.9	175.9	117.0	109.5	135.1	135.8

Source: Collins, Selwyn D.: Frequency of Health Examinations in 9,000 Families, Based on Nation-Wide Periodic Canvasses, 1928–31. Public Health Reports, 49:321–346 (March 9, 1934), p. 330. Reprint 1618.

The Collins studies also indicate the extent to which the receipt of health examinations is influenced by those received in schools. "Considering examinations at specific ages in the different groups it will be noted that the rates for the upper income classes are consistently higher in the various age groups. At the * * * ages in which most of the examinations are made in school, the rates are practically the same except in families with an income of $5,000 or above. Even these higher income families, rates for children 5 to 14 years old are only about 50 percent in excess of those for the same ages in families with less than $1,200 income; but in both the age groups 45 to 64 and 65 years and over, examination rates for persons in families with $5,000 or more income are about 15 times those in the class under $1,200. In the older ages where most of the examinations are the work of private practitioners, income is a very important factor in their frequency." [38]

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[37] Collins, Selwyn D.: Frequency of Health Examinations in 9,000 Families, Based on Nation-Wide Periodic Canvasses, 1928–31, Public Health Reports, 49 : 321–346 (March 9, 1934), Reprint No. 1618.

Nursing care is another service which is of a less emergency nature and which is expensive—two characteristics which influence the difference in the receipt of care between high- and low-income groups. The following table is illustrative.

TABLE T.—*Annual days (shifts) of private duty nursing per 1,000 persons in canvassed white families of different income levels in 18 States during 12 consecutive months, 1928–31*

Annual family income	All ages—adjusted rate			Age					
				Under 20		20 to 44		45 and over	
	Total	Surgical	Non-surgical	Surgical	Non-surgical	Surgical	Non-surgical	Surgical	Non-surgical
Under $1,200	88	24	64	10	17	41	81	42	144
$1,200 but under $2,000	182	50	132	8	44	75	218	158	231
$2,000 but under $3,000	228	91	137	34	30	134	260	179	183
$3,000 but under $5,000	390	158	232	42	66	235	342	282	415
$5,000 and over	1, 285	519	766	390	413	530	840	711	1, 245

Source: Collins, Selwyn D.: Variation in Nursing Service With Family Income and Size of City; Based on Records for 9,000 Families in 18 States Visited Periodically for 12 Months, 1928–1931. Milbank Memorial Fund Quarterly, XXI: 188–213 (April 1943), p. 194.

As the Collins studies point out, private nursing service showed greater concentration in the higher income levels than any other type of medical care except certain types of dental service. Nursing cases and days per 1,000 population and the percentage of cases with a private nurse all showed large excesses in the higher income families.

It is believed that the CCMC study attempted to record all free services provided by physicians, hospitals, and all other types of medical practitioners. The fact quoted by Dr. Friedman from Falk, Rorem, and Ring that "free hospital care is given to 52 percent of all cases occurring in families with yearly incomes of $1,200 or less" demonstrates that free care was reported. The volume of service provided to each income class includes free care as well as that for which a charge was made. Surgery provided to persons in the group with less than $1,200 income that received free hospital care, for example, is included in the total volume of surgery.

UNATTENDED ILLNESS AND THE NATURE OF RECORDED ILLNESS

In a discussion of the types of recorded illness, such as that presented by Dr. Friedman, it is well to keep in mind the fact that the number of illnesses reported depends on the frequency of the enumerator's visits to the family. If data on a year's illness are obtained at a single visit, many minor illnesses such as colds are forgotten and proportionately more of the serious or longer illnesses are recalled and reported. In the C. C. M. C. study, the visits were made at intervals of 2 to 4 months, and an illness rate of approximately one case per person per year was obtained; for minor respiratory illnesses, including the common cold, an annual rate of 0.3 was found. But a special study has shown that a rate of three cases per year for colds alone was obtained when the persons giving the information understood that all colds of even the mildest type were to be reported and when visits were made at intervals of 2 weeks or less.[39]

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[38] Ibid.

As Dr. Friedman points out in the section discussing unattended illness, "The disparity between the highest and the lowest income groups is even more marked when attention is focused on the number of unattended illnesses rather than on the number of persons with unattended illness. In families with less than $1,200 per year income, 33.5 out of every hundred illnesses were unattended." Dr. Friedman then asks, "When we recall that over half of the recorded illnesses were ambulatory, and that almost half were not disabling, should we be greatly alarmed that one third of the illnesses were unattended?"

Mention has been made earlier of the unfortunate inference of this question, if Dr. Friedman means to imply that a patient must be disabled and unable to visit the doctor before receiving medical care. The major question, rather, is "Are illnesses needing medical attention receiving the necessary care?" If only the more serious types of illness are considered, for example, those requiring surgery, some indication of the difference in the amount of service provided to the various income groups is available. The frequency with which surgery was obtained varied from 52 operations per 1,000 persons in families with annual incomes of less than $1,200 to 94 in families with $5,000 or more income (age adjusted). The rates for each income group for 10 fairly specific types of operations are shown in table U, the rates in each income class having been adjusted for age differences.

TABLE U.—*Frequency of certain surgical operations among canvassed white families of different income levels in 18 States during 12 consecutive months, 1928–31*

Nature of operation	Annual operation rate per 1,000 population (age adjusted)				
	Under $1,200	$1,200 but under $2,000	$2,000 but under $3,000	$3,000 but under $5,000	$5,000 and over
All operations	51.98	55.98	69.83	66.12	94.48
Tonsillectomy and adenoidectomy	15.21	15.43	17.43	20.11	29.36
Ear and mastoid operations	1.34	2.00	2.18	2.84	6.45
Appendectomy	5.77	3.56	7.14	5.92	8.17
Miscellaneous other abdominal operations	4.14	3.93	4.32	3.67	6.28
Lancing of boil or abscess	1.42	1.48	2.84	2.05	3.82
Removal of tumors (except of the female genital organs)	1.43	1.60	5.10	3.20	8.68
Operations on the female genital organs (per 1,000 females)	7.21	12.96	12.62	9.11	10.65
Circumcision [1] (per 1,000 males)	1.74	2.62	4.86	3.04	2.73
Bone set	8.89	7.43	8.13	6.55	5.56
Operations on injuries (except setting of bone)	3.89	6.05	6.17	6.53	9.00
Miscellaneous other operations	5.07	6.40	7.73	8.43	9.51

[1] Circumcisions under 1 year of age per 1,000 male live births.

Source: Collins, Selwyn D.: Frequency of Surgical Procedures Among 9,000 families; Based on Nation Wide Periodic Canvasses, 1928–31. Public Health Reports, 53:557–628 (April 22, 1938). Reprint 1926, p. 19.

Table V shows that the operations occurred with greater frequency in the upper than in the lower income brackets. It is of even greater importance to observe for specific diagnoses in which surgery is important the proportion of cases that were treated surgically in each of five income groups.

The proportion of appendicitis cases treated surgically varies from 52 percent in families with annual incomes under $1,200 to 75 percent for cases in families with $5,000 or more income, although the increase is not steady. The higher proportion of accidents, except poisoning, that received surgical treatment in the lower income groups is probably due largely to treatment of fractures received in industrial accidents which occur more frequently in low-income groups.

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[39] Collins, Selwyn D., and Gover, Mary: Incidence and Clinical Symptoms of Minor Respiratory Attacks With Special Reference to Variation With Age, Sex, and Season, Public Health Reports, 48: 1155–1178 (September 22, 1933).

TABLE V.—*Percentage of cases treated surgically in families of specified annual income*

Diagnosis and age	Under $1,200	$1,200 but under $2,000	$2,000 but under $3,000	$3,000 but under $5,000	$5,000 and over
Tonsil and other throat diseases:					
All ages [1]	34.3	30.1	31.6	31.7	34.5
Under 20	43.8	37.2	35.2	34.4	40.2
20–44	19.8	17.6	25.0	29.0	29.8
45 and over	6.2	4.4	20.6	20.0	17.3
Otitis media and mastoid diseases:					
All ages [1]	16.4	20.6	20.0	24.3	27.9
Under 20	18.5	22.1	23.0	23.6	31.6
20–44	11.1	10.0	4.6	40.0	28.0
45 and over	----------	16.7	20.0	----------	----------
Appendicitis:					
All ages [1]	51.7	45.9	66.3	60.4	74.5
Under 20	50.0	33.3	60.0	58.3	79.2
20–44	52.0	53.7	69.5	66.7	76.2
45 and over	66.7	50.0	66.7	33.3	50.0
Boils and abscesses:					
All ages [1]	11.5	11.3	21.2	10.1	18.7
Under 20	16.0	9.4	26.2	7.4	15.6
20–44	10.0	13.8	17.6	12.9	20.0
45 and over	----------	10.5	----------	9.1	18.2
Female genital and puerperal, except live births:					
All ages [1]	16.7	24.9	26.6	21.5	25.5
Under 20	8.3	10.7	----------	----------	----------
20–44	18.0	26.4	29.5	23.6	31.9
45 and over	14.3	18.5	25.0	16.7	15.8
Accidents, except poisoning:					
All ages [1]	22.3	20.8	19.3	16.3	17.1
Under 20	22.8	20.3	19.2	15.0	17.2
20–44	16.4	21.9	18.9	20.7	12.2
45 and over	29.6	20.2	21.0	9.8	23.7
All other diagnoses:					
All ages [1]	1.6	1.9	2.9	2.3	3.2
Under 20	1.0	1.4	2.2	1.4	2.2
20–44	2.5	2.4	3.5	3.2	3.8
45 and over	2.0	2.8	4.3	3.3	4.4

[1] "All ages" includes a few of unknown age.

Source: Collins, Selwyn D.: "Percentage of illnesses treated surgically among 9,000 families; based on Nation-wide periodic canvasses, 1928–31." Public Health Reports, 53: 1593–1616 (Sept. 9, 1938). Reprint 1981, table 5, p. 19.

No comment is offered on Dr. Friedman's references to data from the Dodd and Penrose study Economic Aspects of Medical Services. Although described by Dr. Friedman as "probably the most pertinent body of data on the question of unattended illness" and used by him as the basis for calculations of the frequency of unattended illness, it is assuredly true, as he states, that the "findings cannot be applied to the people of the United States as a whole. The population of California simply is not truly representative of the population of this country."

COSTS OF MEDICAL CARE

The total national expenditures for medical care in the United States in 1929, as Dr. Friedman states, were estimated by the Committee on the Costs of Medical Care at 3.66 billion dollars, representing expenditures by patients, Government, philanthropy, and industry. The services provided under health insurance would, in general, represent a large proportion of the services now purchased by individuals on a private postpayment basis (see table W).

TABLE W.—*Total expenditures for medical care in the United States*[1]

[All figures in thousands of dollars]

Service	Total	Sources of funds				Per capita (1929)
		Patients	Governments	Philanthropy	Industry	
Total	$3,656,000	$2,885,790	$509,500	$181,710	$79,000	$30.08
Physicians in private practice [2]	[3] 1,090,000	[3] 1,040,000			50,000	8.97
Dentists in private practice [2]	[3] 445,000	[3] 445,000				3.66
Secondary and sectarian practitioners	193,000	193,000				1.59
Graduate nurses, private duty	142,000	142,000				1.17
Practical nurses, private duty	60,000	60,000				.49
Hospitals:						
Operating expenses	656,000	278,000	300,000	54,000	24,000	5.40
New construction	200,000		100,000	100,000		1.64
Public health	121,000		93,500	27,500		1.00
Private laboratories [4]	3,000	3,000				.02
Orthopedic and other supplies	2,000	2,000				.02
Glasses [4]	50,000	50,000				.41
Drugs [4]	665,000	665,000				5.47
Organized medical services [5]	29,000	7,790	16,000	210	5,000	.24

[1] With a few minor and unimportant exceptions the data apply to the year 1929. They are probably representative of any normal year of recent times (to 1933).

[2] Physicians and dentists holding part-time salaried positions are included with private practitioners. Expenditures for the services of those employed in hospitals, clinics, public health departments, and organized medical services are included under total expenditures for the respective agencies.

[3] These totals include payments by Government and philanthropic agencies to private practitioners for services to indigent persons.

[4] Not included in other items.

[5] University, industrial, and Army and Navy medical services, exclusive of hospital care.

Source: Falk, I. S.; Rorem, C. Rufus; Ring, Martha D.: The Costs of Medical Care (CCMC, Pub. No 27), Chicago, University of Chicago Press, 1933, ch. II, p. 9, table 1.

In general, it has been assumed that services could be provided under a health-insurance plan for a total amount not substantially greater than is now being expended by individual families for the same classes of services; the major difference would be that the expenditures would be more evenly divided and that more adequate and more timely services would be assured. The latest figures on family expenditures for medical care on a national basis were those collected in the recent studies of family spending and savings in wartime. In 1941, according to those studies, 3.4 billion dollars was spent by civilians for medical care; the corresponding figure for 1942 was estimated at 3.7 billion dollars.[40] In 1941, the average expnditure for medical care among urban families was $96, and by 1944, the average had increased to $133. No recent data are available on expenditures by rural families, but it seems reasonable to assume that medical expenditures increased in rural areas also.

As far as contributions toward hospital construction and operating expense are concerned, the operation of a health-insurance program need in no way interfere with the present arrangements, but hospitals would be assured of a larger income through the wider availability of funds and lower per diem costs for services now provided. Above all, the program would assure greater use of existing hospital facilities and an effective demand for facilities where they are now lacking. It is not expected that a health-insurance program would cause a reduction in many kinds of medical services now financed by government, but rather would permit a reallocation of Government funds for various types of medical-care needs. For example, funds now spent for medical care of needy persons might be diverted to expand services for mental hygiene and assure more adequate provision for mental patients.

Dr. Friedman develops the cost of providing the volume of service outlined as adequate in the Lee-Jones report.[41] The Lee-Jones standards, however, do not represent the volume of care to be given under a health-insurance program. While it is expected that many persons will receive much more adequate care than at present, and at a price they can afford to pay, the program proposed does not assume that all persons will receive completely adequate care. There are necessary limitations on service; for example, the services which might be provided, as outlined in S. 1320, include physicians' services in the office, home, and hospital; 60 days of hospital care a year; necessary laboratory services; eyeglasses and some other special appliances; prescribed drugs and medicines of the more expensive types; and limited amounts of dental and home-nursing service.[42] The amount of service provided under any health-insurance plan is necessarily controlled by personnel and facilities available. If funds were ample, services which in the beginning had been provided in limited amounts would be expanded.

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[40] Office of Price Administration: Civilian Spending and Saving, 1941 and 1942, Washington, March 1943, p. 12 (processed).

[41] Lee, Roger I., and Jones, Lewis W.: op. cit.

Dr. Friedman quotes the administrative costs of the Michigan medical service in its initial years of operation and at a later period, but he does not take account of the fact that such costs are not comparable with the administrative costs that would be encountered under a compulsory health-insurance system. The Michigan medical service and the Blue Cross hospital plans, whose administrative expenses are also quoted, incur considerable cost in advertising, soliciting, and renewing their contracts. Under a compulsory health-insurance system, such "acquisition costs" would be entirely eliminated.

The estimated per capita costs of a health-insurance system, as given in Senate committee print No. 5, appear in table X. These cost estimates were prepared in 1946; price levels have since increased.

TABLE X.—*Summary of illustrative per capita costs*

Benefit	Initial or early year per capita costs		195X per capita costs	
	Amount	Percent	Amount	Percent
	At 1941 price and income levels			
Total	$20.20	100.0	$27.33	100.0
1. Physicians' services	9.72	48.1	10.79	39.5
2. Hospital minimum-service benefit	5.75	28.5	7.48	27.4
3. Dental care	2.00	9.9	4.75	17.4
4. Home nursing	.38	1.9	.93	3.4
5. Laboratory, medicines, and appliances	2.25	11.1	2.86	10.5
6. Research and education	.10	.5	.52	1.8
	At current and prospective price and income levels			
Total	$28.76	100.0	$38.93	100.0
1. Physicians' services	14.58	50.7	16.18	41.6
2. Hospital minimum-service benefit	7.19	25.0	9.35	24.0
3. Dental care	3.00	10.4	7.13	18.3
4. Home nursing	.51	1.8	1.24	3.2
5. Laboratory, medicines, and appliances	3.38	11.8	4.29	11.0
6. Research and education	.10	.3	.74	1.9

Source: United States Senate Committee on Education and Labor: Medical Care Insurance, Senate committee print No. 5, Washington, 1946, p. 147, table 18.

The estimated effect of a health insurance system on family expenditures for medical care is shown in table Y for families in four different income classes.

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[42] United States Senate; S. 1320 (80th Cong., 1st sess.), title II, pt. A, sec. 201.

TABLE Y.—*An illustrative comparison of insurance premiums and customary family expenditures for medical care*

Annual earnings	Insurance premiums at—		Average family expenditures for medical care in 1941	
	4 percent	3 percent	Total [1]	70 percent of total
$750	$30	$22.50	$41	$29
$1,250	50	37.50	62	43
$2,500	100	75.00	105	74
$3,600 and over	[2] 144	[2] 108.00	204	143

[1] Based on Spending and Saving of the Nation's Families in Wartime, Bureau of Labor Statistics, Bulletin No. 723, tables 8 and 9, 1942. For the illustrative purposes of this tabulation, the expenditures for families in broad income groups are ascribed to families with annual earnings at the midpoints of the income groups. The figure for families with earnings of $3,600 and over ($204) is the weighted average of expenditures of $151 for families with $3,000–$5,000 and $310 for families with $5,000 and over.

[2] If there is more than 1 income recipient in the family, the total premiums would be higher than is indicated here, because the 4- and 3-percent rates on the maximum amount of $3,600 would be paid by each income recipient. Thus, there is some understatement of premiums for families with annual earnings in this bracket.

Source: U. S. Senate Committee on Education and Labor: Medical Care Insurance, Senate Committee Print No. 5, Washington, 1946, p. 158, table 18.

As Senate Committee Prints Nos. 4 and 5 both point out, a national health insurance plan would, in general, represent a substitute for the family disbursements already being made for medical services. Many health insurance proposals have suggested that the employers share the costs of the premiums with the employees. To the extent that part of the health insurance premium is paid by the employers and not passed on to consumers, the insurance arrangement would relieve the families of still more of their private expenditures than table Y indicates. In the table it is assumed that all the premium is to be paid by the employees, and the amount that would be paid under both a 4- and 3-percent contribution is given.

Table Y shows total family expenditures as well as 70 percent of the total, because it is estimated that, on the average, 70 percent of the family medical care expenditures were made for the services that might be covered by a health insurance system. Account is also taken of the fact that only part of the aggregate present expenditures for dental care, special nursing, and drugs and medicines would be covered in the proposed plan.

HOW MANY FAMILIES COULD AFFORD MEDICAL CARE AT $100 A YEAR?

Dr. Friedman's basic error in this section is the assumption that all families would pay equal premiums under health insurance, for, under S. 1320, the amount of premium would vary with earnings. If insurance premiums are payable at a rate of 3 percent of earnings, families with one worker with wages of $2,500 a year would contribute $75 into the health insurance fund; one-worker families with wages of $750 would contribute $22.50. The advantage of paying for medical services through health insurance as against the usual method of purchase of medical services on a fee-for-service basis is the fact that premiums are automatically geared to ability to pay. In a health insurance system of the kind under discussion financed largely through pay-roll deductions, the contributions are paid by the employed members of the family and entitle the worker and his dependents to medical services. Some families have more than one worker; in these cases each worker would pay 3 percent of his earnings into the health insurance fund. A family with two workers, each of whom earned $1,250 a year, would contribute $75, the same amount as that contributed by a family having only one worker earning $2,500. The maximum contribution of any worker at a 3-percent contribution rate would be $108, since $3,600 is the maximum amount of annual earnings assumed to be taxed in the study cited.

The significance of Dr. Friedman's discussion of the spending pattern of low-income families in Pennsylvania and Ohio, as found in the Study of Consumer Purchases, is not clear. His remarks focus on the finding that families with incomes of $0–$249 spent more for family living than did families with incomes of $250–$499 or $500–$749. Yet Dr. Friedman quotes from the Consumer Purchases report as partial explanation of this "paradox"—that the low-income group apparently included families having resources sufficient to enable them to live beyond their incomes in that specific year.

A further explanation is found in the report itself. The authors of the report, in discussing the relatively high consumption expenditures of the lowest income group, state:

"* * * consumption was probably not adapted to the income of the year in question but was maintained at customary levels. Thus in the income class $0–$249, the value of consumption of 3 of the 22 families in the sample was within the range $2,000–$2,499; in the class $5,000–$9,999, the value for 3 of the 19 families was less than $1,500. In the lowest and in the highest income classes, in which the number of families in the sample was small, these cases of extreme variation exerted considerable influence on the average expenditures of the group." [43]

The report goes on to say that if the sample of families in the lowest income class had been larger, the average value of consumption probably would have been much lower than the average for the families covered in the survey. With the reliability and representativeness of the data for the $0–$249 income group admittedly questionable, there seems little reason for pointing up the difference in expenditures between this and the two higher income classes.

HEALTH INSURANCE PLANS NOW AVAILABLE

Detailed studies of voluntary health insurance plans have been and are being made by personnel of the Federal Security Agency in cooperation with the plans.[44] These plans are making valuable contributions in providing hospital and medical services on a prepayment basis.

In large part, however, Dr. Friedman's description of these plans is inaccurate. No attempt will be made here to list all inaccuracies and prove them to be such, since most of the points raised by Dr. Friedman are adequately covered in the above-mentioned studies. Nevertheless, a few points deserve brief mention.

Dr. Friedman has failed to give a complete account of the plans that actually are available, for he entirely disregards those sponsored by groups of physicians in private practice, by consumer organizations, and by various Federal and local government agencies. He has apparently overlooked the fact that many of these programs have been in operation for a much longer time than the Blue Shield plans sponsored by medical societies; that many provide a far more comprehensive type of service than do most medical society plans, and that they have something definite to contribute to programs for extensive medical coverage.

In stating that Blue Cross and Blue Shield plans are capable of covering the entire population, Dr. Friedman has ignored the fact that no voluntary plan here or abroad has ever achieved the goal of complete coverage. Those most in need of care—the indigent and families of low income—are the ones who usually fail to receive it through voluntary prepayment. Many of those who have insufficient gainful employment would not even be covered under a compulsory system of social insurance, if some form of subsidy were not provided. Under a voluntary system—where the rates are high because of the constant exposure of the system to adverse risks resulting from voluntary participation and because of the expenses of soliciting new members—the cost of coverage would be considerably higher than under a compulsory program. Today, approximately 15 years after the beginning of Blue Cross, only one-fifth of the population is covered for hospitalization. The Blue Cross Bulletin of December 1946 reported that only 2.65 percent of the rural population had Blue Cross protection, according to enrollment on July 1, 1946, as compared with approximately 27 percent of the urban population of the country.

Dr. Friedman is of the opinion that if provision were made for the cost of catastrophic illness, for most people the only charges left to be paid out of current income would be those occasioned by relatively minor afflictions which need only a visit or two from the family doctor. In introducing the Maternal and Child Health Act of 1945, Senator Claude Pepper of Florida called attention to the fact that even in the relatively good year of 1940, about half of the children in the country were living in families with incomes of less than $20 a week. The burden which even minor illness places upon this income group is self-evident. Senator Pepper also pointed out that "good maternity care cannot be purchased with the left-overs from $20 a week after food, clothing, and shelter for a family are paid for. Such care costs even the Government, under the emergency maternity and infant care program for servicemen's wives and babies, about $90. And this is only the beginning of the good medical care and health supervision which every child should have until he is full-grown." Dr. Friedman minimizes two of the major problems in a medical-care program—the care for nonhospitalized illness and the provision of preventive services.

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[43] U. S. Department of Agriculture: Family Income and Expenditures, Five Regions: Pt. 2. Family Expenditures, Miscellaneous Publication No. 465, Washington, 1941, pp. 43–44.

[44] Klem, Margaret C., Social Security Administration: Prepayment Medical Care Organizations. Bureau Memorandum No. 55, Washington, Social Security Administration, Bureau of Research and Statistics, 3d edition, June 1945.

Reed, Louis S., U. S. Public Health Service: Blue Cross and Medical Service Plans, Washington, U. S. Public Health Service, 1947 (in press).

Hunt, G. Halsey, U. S. Public Health Service: Medical Groups in the United States, 1946, Washington, U. S. Public Health Service, February 1947.

Hunt, G. Halsey: Medical Group Practice in the United States. I. Introduction, New England Journal of Medicine (in press).

In commenting on some features of Dr. Friedman's description of voluntary health insurance plans, our purpose is not to belittle the Blue Cross and the medical society plans. The Blue Cross plans—operating on a nonprofit, prepayment basis and permitting subscribers to select a hospital of their choice from among member hospitals—have assisted millions of persons in paying hospital bills. They have facilitated the collection of charges and thus have assisted hospitals in stabilizing their income. The medical society plans—more recent in development and with a much smaller enrollment—have been beneficial to subscribers and the medical profession.

One cannot conclude from a review of existing voluntary plans, however, that such plans can ever provide adequate medical care on a prepayment basis for the total population of the United States. With specific reference to Blue Cross and medical society plans, it must be pointed out that, with few if any exceptions, these plans provide restricted services; they exclude many conditions requiring medical care; they require long waiting periods for certain conditions; they do little or nothing to prevent illnesses in early stages from becoming serious; they do little to improve the quality of services or to make for a more efficient provision of services to the public; and they (particularly the medical society plans) do not provide for adequate public or subscriber participation in the control of the plans.

Among Blue Cross and medical society plans there is wide variation in benefits, subscription rates, in conditions for which care is provided, and in enrollment procedures and restrictions. Such variations have impeded their enrollment of employees of Nation-wide firms and members of national unions—organizations interested in obtaining uniform benefits at uniform rates for all employees wherever located.

Although, on the average, these plans are allocating a reasonable percentage of income for administrative expenses—approximately 13 percent—some plans devote more than twice that amount to administration.[45] Some plans, moreover, allocate excessive amounts for reserves, thereby limiting the amounts currently available for benefits.

In a few areas, Blue Cross and medical society plans have been in competition with each other, and in other areas effective coordination between these plans has not been achieved, even though their objectives require close coordination.

These and other limiting factors—e. g., subscription costs beyond the means of millions of persons—must be considered whenever voluntary health insurance plans are offered as the answer to national programs for medical care.

REFLECTION OF SOME OF THE PROVISIONS *of* S. 1320 [46]

Under this heading, Dr. Friedman criticizes the national health insurance and public health bill of 1947 (S. 1320), using most of the arguments that have already been presented by critics of the legislation. The various units of the Federal Security Agency have expressed their comments on S. 1320 in some detail in their official reports on the bill and in testimony before the Senate committee. No attempt will be made, therefore, to consider all the details of Dr. Friedman's position, except for brief comment on a few of the more important points he raises.

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[45] Reed, Louis S.: op. cit., and Council on Medical Service, American Medical Association: Voluntary Prepayment Plans, Chicago, 1947.

[46] This discussion covers the remaining four sections of Dr. Friedman's statement.

In much of his discussion, Dr. Friedman seriously misinterprets the bill, and in some instances is grossly in error regarding its provisions. His claims that ward hospital accommodations are mandatory, that tuberculosis and mental disease patients are ineligible for any hospital care, that every individual must contribute 4 percent of his earnings, and similar assertions can be readily refuted by reference to the appropriate sections of S. 1320.

Dr. Friedman's comments on administrative costs deserve special scrutiny. His estimate of the ratio of 1 administrative employee per 100 insured is the same as that given in 1946 by Dr. Lowell S. Goin (April 17, 1946) in his testimony before the Committee on Education and Labor in hearings on S. 1606. Dr. Goin cited as his source of information, J. G. Crownhart, Sickness Insurance in Europe, 1938, page 25. An inspection of this reference indicates no evidence to support Mr. Crownhart's conclusion, which is obviously an error since it implies administrative costs far in excess of what European nations now spend in administering their insurance programs. Since Crownhart himself elsewhere (p. 51) states that the administrative costs reported do not exceed 17 percent in any country and "most of them are in the neighborhood of 10 to 12 percent," it is evident that his estimate of 1 employee per 100 insured cannot be correct.

Figures on administrative costs in Germany are available for medical benefits and cash payments for wage loss during sickness for the period 1928–37. They varied from 6.5 to 10.4 percent of total expenditures. In that country, during the period 1929–36, there were actually 0.7 to 0.9 full-time office employees per 1,000 persons eligible for medical benefits (insured workers and their dependents). During 1934–36, for which information is available on all administrative personnel, including part-time personnel,[47] there were .098 per 1,000 persons eligible for medical service.[48] This personnel was responsible for the administration of cash sickness benefits as well as medical care services.

The number of administrative personnel required to carry out the personal health service provisions of S. 1320 would probably not be more than half the number the German health insurance program would suggest. This assumption seems reasonable since S. 1320 makes no provisions for cash benefits, and probably about one-third of the personnel used in the German health-insurance program administer the provisions for cash benefits. In Germany, furthermore, some of the personnel of the health-insurance program collect contributions. Under S. 1320 no separate machinery would be needed for the collection of contributions, since that now functioning for the Federal old-age and survivors' insurance program would be used. Perhaps most important of all is the fact that the health-insurance program in Germany was administered through 5,000 to 6,000 separate local funds with greatly differing provisions. Furthermore, all accounts and records are posted manually. Under the provisions of S. 1320, however, coverage would be uniform throughout the Nation. There would be no competing organizations for collection of contributions and for making arrangements for the services to be given. Determination of eligibility would be Nationwide in scope. There would be extensive use of labor-saving devices. It is our judgment, therefore, that administrative personnel requirements for personal health services may not be expected to exceed 60,000 persons, or about 1 employee per 2,000 insured individuals.

Dr. Friedman also misinterprets the provisions of section 203 of S. 1320 regarding free choice and change of physician, and makes some rather erroneous statements concerning the Rhode Island disability-insurance program citing Dr. Victor Johnson as his authority. There is no compulsory insurance for medical care in Rhode Island and there has never been any. What Rhode Island does provide is cash payment for wage loss during disability. The program is not financed by industry or by the State, but exclusively by the contribution of employees. The only "participants" in the program to which Dr. Friedman refers (other than administrative officers) are persons employed in industries covered for unemployment compensation. Since the program makes no provision for medical care, it could not have interfered with the quality of medical care. The experience in Rhode Island could not, therefore, have much direct bearing on Nation-wide compulsory health insurance.

In the original Rhode Island law only 1 percent of the total annual yield of contributions was allowed for all administrative costs, in the hope that personnel of the State unemployment compensation board—paid from Federal funds under title III of the Social Security Act—would be available for the cash sickness-benefit program. When it was found that this source could not be used, administrative funds were increased to 3 percent and later to 4 percent.

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[47] Figured on the basis that two part-time persons accomplish the work of one full-time employee.

[48] Annual issues of Die Krankenversicherung, Statistik des Deutschen Reichs and Amtliche Nachrichten für Reichsversicherung.

The step taken toward decentralization to which Dr. Friedman refers was not in all aspects of administration but merely to provide several places where certain claimants might be examined by a physician designated by the State board, to substantiate their incapacity for work. During the first benefit year all such claimants were required to go to the Providence office for examination.

Dr. Friedman ends his statement on his opening note. "The chief killers," he states "are heart disease, cancer, chronic vascular disease, nephritis, tuberculosis, pneumonia. The chief causes for prolonged disability are mental disease, heart disease, tuberculosis, and vascular disease. *The medical services of this country could be expanded to infinity without influencing one iota the incidence of these maiming and killing diseases*" [italics added]. As indicated earlier, such lack of faith in the achievements of modern medical science seems indefensible. We doubt that any competent medical or public-health authorities would support such a statement. Much can be done to prevent, control, ameliorate, or remedy these and other defects. A national-health program which proposes to make health care more widely available and to encourage research into the unconquered realms of medicine certainly should not be rejected on the grounds that medical services are not of any real value to the health of the Nation.

The Federal Security Agency is impressed with the evidence of the Nation's unmet health needs. The Agency is convinced that, whatever the final method of financing that is established, the American medical professions and American scientific investigators will successfully bring greater health security to ever-increasing proportions of the population.

APPENDIX A

FEDERAL SECURITY AGENCY,
UNITED STATES PUBLIC HEALTH SERVICE,
Washington 25, D. C., July 9, 1947.

Mr. WATSON B. MILLER,
Administrator, Federal Security Agency,
Washington 25, D. C.

DEAR MR. MILLER: In following the hearings on bills S. 545 and S. 1320, before a subcommittee of the Committee on Education and Labor, United States Senate, Eightieth Congress, it is felt by this office that certain testimony was given regarding mental disease which might quite easily be misinterpreted. It was stated in part that:

"Mental disease was the primary cause for rejection in the case of 12.50 percent of all men rejected under selective service in the period April 1942 to March 1943, and in the case of 17 percent of all men rejected in the period April 1943 to December 1943. An additional 4.10 and 4.02 percent of all rejections during these two periods, respectively, were due to neurological conditions (including chronic encephalitic syndrome, epilepsy, posttraumatic cerebral syndrome)."

With reference to the above, we understand the following question was asked:

"On the basis of present knowledge could adequate health measures, preventive and curative, have appreciably lowered draft rejection from these causes?"

If this implies that adequate health measures, preventive and curative, could not have appreciably lowered draft rejections from nervous and mental diseases, this office would like to go on record to the contrary.

From data available from the Office of Selective Service Records, it is estimated that the following number of registrants 18 to 37 years of age in class IV–F and classes with "F" designation were rejected as follows:

Mental diseases	856,200
Neurological defects	235,400

Of the total number rejected for mental disease, hardly more than 1 in 10 were rejected for grave mental or personality disorders, while approximately 8 out of 10 rejections were for psychoneurotic disorders and psychopathic personality. About one-third of the neurological rejections were due to epilepsy or epileptic equivalents; a considerable proportion of the remainder of neurological defects included the residuals of infantile paralysis and posttraumatic cerebral syndrome.

While it is not the purpose of this communication to present detailed evidence on the extent to which patients with specific nervous and mental disorders are susceptible to recovery, improvement, or control, there seems little doubt that the weight of the evidence will support the following conclusions:

1. Patients admitted to mental hospitals with the gravest mental disorders, the psychoses, do recover or improve to an appreciable extent under appropriate treatment and there is cause to believe that the prognosis for such patients is becoming more and more hopeful.
2. Mental hospitals offering intensified therapy to patients not only get a higher proportion of recoveries and improvements but reduce the time required for treatment.
3. Mentally ill persons with milder mental disorders have a definitely more hopeful prognosis than patients with psychoses.
4. Mentally ill persons who come under treatment when their condition is in its incipiency or early stages have a better prognosis than more advanced cases. Early treatment is thus a form of prevention.
5. If one were disposed to search the literature regarding the prognosis of patients with specific classifications of mental disease, one could find proportions of patients recovered and/or improved ranging from 0 to 100 percent. For the conditions regarded as less grave, proportions in excess of 50 percent recovered and/or improved are not uncommon.

While it must be admitted that our present knowledge of the etiology of most mental disorders is inadequate, there is certainly nothing to be gained by a return to the neglect and do-nothing attitude which has been accorded to such conditions of mental ill health in years past. If progress has been slower in understanding and controlling many of the mental diseases it is because insufficient attention has been given to these conditions. In contrast with the more specific exogenous causes of most physical diseases, there is increasing evidence in mental ill health of the importance of the development of faulty habits of feeling, thinking, and acting by the patient during childhood. It should not be expected that understanding and control of mental disease will be gained by the discovery of biochemical or physiological specifics, as was the case with diphtheria and typhoid, but rather by a long and tedious educational campaign as was the case in tuberculosis. To implement adequate health measures, preventive and curative, with reference to mental disorders, it will be necessary that family physicians, nurses, pediatricians, and a large number of ancillary personnel be educated to the idea of recognizing that various complacently regarded symptoms as well as certain oddities of behavior may be the prerunners of a severe and chronic mental disease, just as certain physical signs such as cough or loss of weight may be the first indication of a serious physical disease.

Because adequate provisions have not been provided in past years to prevent or greatly alleviate mental ill health does not mean that nothing can be done. To say that a problem is difficult is not to say that it is impossible. The question referred to above should therefore be answered affirmatively.

Sincerely yours,

R. H. Felix,
Medical Director, Chief, Mental Hygiene Division.

APPENDIX B

American Heart Association, Inc.,
New York 19, N. Y., July 9, 1947.

Statement for Watson B. Miller

On the basis of present knowledge, adequate health measures, preventive and curative, could have lowered draft rejections for the various cardiovascular disorders you have listed.

This statement is based on the following facts in regard to heart disease, considered on an etiological basis.

1. BACTERIAL ENDOCARDITIS

A large percentage of these cases are now curable with adequate penicillin therapy.

2. CONGENITAL LESIONS

Patent ductus arteriosus, coarctation of the aorta, various anomalies of the aorta and its main branches are now correctible by surgical operations. Other congenital defects can be treated, although not cured by surgical procedures.

3. EFFORT SYNDROME

(Many of the cases listed under hypertension, arterial, and tachycardia, fall in this group.) Better psychiatric care during the early years of life should appreciably reduce the number of cases in this category.

4. HYPERTHYROIDISM

Heart diseases due to this cause can be prevented by medical and surgical treatment.

5. RHEUMATIC FEVER

At present, it is impossible to prevent initial attacks of this disease. It is true that rheumatic heart disease often occurs as the result of the first attack. Often, however, repeated attacks of this infection lead to rheumatic heart disease. Proper sulfonamide or penicillin prophylactic therapy can prevent recurrent attacks.

6. SYPHILIS

Cardiovascular syphilis is preventable in over 90 percent of the cases by adequate therapy of early syphilis.

7. HYPERTENSION

Since the exact cause of essential hypertension is still unknown, nothing can be done at the present moment to reduce the disability due to this disease.

8. ARTERIOSCLEROSIS

This also is not preventable at the present moment. It is reasonable to state, however, that progress is being made rapidly in this field.

In addition to these specific comments, it is only fair to consider two other aspects of the question which should be mentioned.

1. The very figures for rejections for cardiovascular diseases are one of the strongest arguments for further research into the causes of the diseases, as they are the leading cause of death in the United States.

2. These figures apply only to a limited number of the population of this country, i. e., males from the age of 18 to 38. The remainder of the population is not considered. Furthermore, it is to be emphasized that although these men were rejected for service in the armed forces, many of them were fully capable of leading a useful and productive life in various civilian industries and occupations.

(At this point Senator Smith submitted the following correspondence:)

July 14, 1947.

Hon. J. Howard McGrath,
Senate Office Building, Washington, D. C.

My Dear Senator: This will acknowledge receipt of your letter of July 9 with enclosures which you request me to place in the record of the hearings that we are holding on the health bills. I will be very glad, as you request, to insert in the record your letter to me together with the enclosures, so that we can have the benefit of what is being done in Rhode Island.

Your experiment in Rhode Island seems to me the right way to approach this matter, rather than have us try to establish a compulsory law for the entire United States. If Rhode Island and California, for example, should like to try the compulsory plan, it would be a real experiment in a practical way to see how best to get at this problem we are all studying. In the bill which I introduced with Senator Taft and others, our purpose was to encourage the States to develop their own plans with Federal aid, to the end that we might find out by the trial-and-error method the best way to arrive at a sound solution for this difficult problem.

Always cordially yours,

H. Alexander Smith.

UNITED STATES SENATE,
July 9, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: On June 25 before your committee, a Dr. Maurice Friedman made a slighting reference to Rhode Island's compulsory sickness indemnity fund. Despite the fact that the program was entering its fifth year and that records proving its successful operation were available, Dr. Friedman based his remarks only on its first year's operation. This I regard as a biased and completely unscientific approach.

I am submitting herewith, and I should like placed in the record along with Dr. Friedman's statement, two articles. One appeared in the Washington Post on July 6. It is entitled "Sickness Insurance Paying Way" and it points out that the program is so successful that Rhode Island's General Assembly has actually expanded its coverage and reduced the employee's contribution. The second, entitled "Rhode Island Fund for Sick Pays Way," appeared in the New York Times for July 6.

For myself and for the people of Rhode Island I should like to state that our sickness indemnity program is an unqualified success and demonstrates both the practicality and the need for such a national health-insurance program as is set forth in S. 1320.

Sincerely yours,

J. HOWARD MCGRATH,
United States Senator.

[From the Washington Post, Sunday, July 6, 1947]

SICKNESS INSURANCE PAYING WAY

PROVIDENCE, July 5.—Rhode Island's cash sickness compensation fund, the first State-operated health-insurance program in the country, is in the black as it enters its fifth year.

The general assembly has just declared its faith in the program by approving transfer to the fund of $28,000,000 built up in the State's unemployment-compensation fund from employee contributions since 1937.

When Rhode Island legislators enacted the cash sickness law in April 1942, they were pioneering in a field scarcely entered except by social-planning reports such as the Beveridge cradle-to-grave plan in England.

Actually, the sickness fund does not provide for preventive medical care and applies only to workers. Housewives and children, for example, do not receive benefits.

Each claimant must see a doctor within 5 days after the onset of illness and at least once a week thereafter until ready to go back to work. No examinations are required for eligibility, but a physician's statement must accompany every application for benefits.

EIGHTEEN DOLLARS WEEKLY MAXIMUM

For the State's 350,000 workers—all who earn at least $100 in a year—the fund provides cash benefits for a maximum of 20 weeks—15 weeks in maternity cases. The sum varies, depending on earnings, from $6.75 to $18 weekly.

At first the payments were limited to those whose earnings did not continue during illness. Later, the general assembly loosened the statute to make any worker eligible—ditch diggers or bank executives.

Last year the assembly tightened this somewhat with the provision that the total of sickness benefits and unemployment compensation shall not exceed 90 percent of a worker's normal earnings.

Benefits are based on credits built up during the calendar year preceding the claimant's illness. The weekly amount depends on the worker's highest quarterly wage in the previous fiscal year. Duration of payments depends on the length of illness and the total amount of wages earned during the previous year.

Workers contribute a percentage of all earnings up to $3,000 annually. When the bill was passed, workers were paying 1½ percent of earnings to the unemployment-compensation fund. The cash sickness fund was started painlessly by shifting 1 percent to it and leaving one-half percent for unemployment compensation.

ONE PERCENT INADEQUATE

In the year between passage of the bill and initial payments in April 1943 a substantial reserve was created. The unemployment-compensation board, which administers the fund, had to dip into this reserve when it was found that 1-percent employee contributions did not equal disbursements. Consequently, the fund was operating in the red soon after disbursements began.

Payments from the cash sickness fund totaled $5,034,675 in 1944, $4,668,796 in 1945, and $4,606,211 in 1946.

The assembly in 1945 transferred the other one-half percent from unemployment compensation. As a result, the fund ended the year 1946 with an income surplus of $179,594 over disbursements.

That $28,000,000 plum from the unemployment-compensation fund was authorized last year by Congress. Congressional approval was needed, since unemployment-compensation contributions are collected by the Federal Government and held in Washington, subject to requisitions by the States. (Rhode Island and California are the only two States which collected contributions from employees as well as employers, and these States were authorized to withdraw money contributed by employees for use in State health-insurance funds.)

Transfer of the $28,000,000 and earmarking of employee contributions was possible because the unemployment-compensation fund, as in other States, has a big surplus. The unemployment-compensation fund still has employer contributions.

The cash sickness reserve is big enough now so that the assembly has cut employee contributions from 1½ to 1 percent.

[From the New York Times, Sunday, July 6, 1947]

RHODE ISLAND FUND FOR SICK PAYS WAY—FIRST STATE HEALTH INSURANCE PROGRAM IN UNITED STATES IS IN BLACK AS IT STARTS A NEW YEAR

PROVIDENCE, R. I., July 5—Rhode Island's cash sickness compensation fund, the first State-operated health-insurance program in the country, is in the black as it enters its fifth year of actual operation.

The general assembly has just declared its faith in the value of the program by approving transfer to the fund of somewhat more than $28,000,000 which had been built up in the State's unemployment compensation fund from employee contributions begun in 1937.

When Rhode Island legislators enacted the cash sickness law in April 1942, they were pioneering in a field scarcely entered except by social planning experts.

Actually, the cash sickness compensation fund does not provide for preventive medical care, and the law's provisions apply only to workers. Housewives and children, for example, do not receive cash sickness benefits.

Each claimant must see a doctor within 5 days after the onset of illness and, with few exceptions, at least once a week thereafter until ready to go back to work. No examinations are required for eligibility, but a physician's statement must accompany every application for benefits or continuation of benefits.

350,000 WORKERS ELIGIBLE

For the State's more than 350,000 workers—all who earn at least $100 in a year—the fund provides cash benefits during a maximum of 20 weeks of illness—15 weeks in maternity cases. The sum received by an individual varies, depending on his earnings, from $6.75 to $18 weekly.

At first the payments were limited to those whose earnings did not continue during illness. Later the general assembly loosened the statute to make any worker, even if earnings continue, eligible for benefits. This goes equally for ditch diggers and bank executives.

However, last year the general assembly tightened this somewhat with the provision that the total of cash sickness benefits and unemployment compensation shall not exceed 90 percent of a worker's normal earnings.

Benefits are based on credits built up during the calendar year preceding the claimant's illness. The weekly amount depends on the worker's highest quarterly wage in the previous fiscal year. Duration of payments depends on the length of illness and the total amount of wages earned during the previous year.

SHIFT OF CONTRIBUTIONS

Workers contribute a percentage of all earnings up to $3,000 annually. When the bill was passed, workers were paying 1½ percent of earnings to the unemployment compensation fund. The cash sickness fund was started painlessly simply by shifting 1 percent to it and leaving one-half percent for unemployment compensation.

In the year between passage of the bill and initial payments in April 1943, a substantial reserve fund was created. The unemployment compensation board which administers the fund had to dip into this reserve when it was found that 1 percent employee contributions did not equal disbursements. Consequently, the fund was operating in the red soon after disbursements began.

Payments from the cash sickness fund totaled $5,034,675 in 1944, $4,668,796 in 1945, and $4,606,211 in 1946.

The general assembly in 1945 transferred the other one-half of 1 percent from unemployment compensation, giving the cash sickness fund the full 1½ percent of worker contributions. As a result, the fund ended the year 1946 in the black, with an income surplus of $179,594 over disbursements.

ADVISORY COMMITTEE SET UP

To make operation of the fund smoother, a board of review and advisory committee were created last year. Another thing that helps smooth the way is that $28,000,000 plum from the unemployment compensation fund. The fund transfer was authorized last year by Congress.

Transfer of the $28,000,000 from the unemployment compensation to the cash sickness fund and earmarking of employee contributions to the latter was possible because the unemployment compensation fund, as in other States, has acquired a big surplus. The unemployment compensation fund still has employer contributions to draw on.

The cash sickness fund's reserve is big enough now so that the general assembly has cut employee contributions from 1½ to 1 percent. Champions of the program say that this time it will stay in the black.

STATEMENT OF JOHN R. MANNIX, PRESIDENT, JOHN MARSHALL INSURANCE CO. OF CHICAGO, ON BEHALF OF THE INSURANCE ECONOMICS SOCIETY OF AMERICA

Senator SMITH. Before you give your testimony, will you make a brief statement for the record of your qualifications as a witness on this matter?

Mr. MANNIX. My personal background has been in hospital administration. I have been connected with hospital administration for 18 years, during which time I became interested in applying the insurance principle to hospital and health care and I was instrumental in starting the hospital plan and Blue Cross plan in 1933.

I organized the hospital and medical plans in Michigan beginning in 1939 and more recently was with the plan in Chicago.

I am now connected with the John Marshall Insurance Co. which confines itself to health insurance, hospital and medical insurance as well as insurance covering loss of income.

Senator SMITH. Specializing in those fields?

Mr. MANNIX. That is right.

Senator SMITH. Is that a new company? Is it the outgrowth of a Blue Cross plan or an old company reorganized?

Mr. MANNIX. It is a new company entirely apart from any Blue Cross plan, although I was formerly connected directly with three Blue Cross plans of Cleveland, Detroit, and Chicago. I was formerly national chairman of the Blue Cross Commission but this was an independent company we established a year ago. It incorporates hospital and medical insurance as well as health insurance covering loss of income.

Senator SMITH. A nonprofit organization?

Mr. MANNIX. A stock insurance company. It is an Illinois corporation.

Senator SMITH. Not what we call a mutual insurance company?

Mr. MANNIX. No; it is a stock insurance company.

Senator SMITH. All right, you may go ahead.

Senator DONNELL. Mr. Mannix, have you stated for whom you are appearing here this morning?

Mr. MANNIX. The Insurance Economics Society of America.

Senator DONNELL. What is that organization, where is it and what is its purpose?

Mr. MANNIX. It is an organization with headquarters in Chicago. It has as members 80 insurance companies, both stock and mutual insurance companies. It also has about 4,000 individual members most of whom are connected with the insurance industry.

Senator DONNELL. How widespread over the country?

Mr. MANNIX. It is pretty widespread, Senator; I could not give you that in detail, but it represents the companies pretty much from coast to coast and as a matter of fact, it has among its membership the American Life Convention which is an organization of the life companies, the American Mutual Alliance, which is an organization of the mutual companies of the country, and it also has the Association of Casualty Insurance as a member; that includes all of the eastern companies in health insurance as well as casualty insurance and also includes Accident and Health Underwriters Conference which for the most part is a western group but also includes a few of the eastern companies.

But, generally speaking, either through individual membership or through these four associations, most of the insurance companies, both stock and mutual, of the country are represented in this organization.

It has, incidentally, an annual budget of around $40,000, most of which is spent in connection with a research program and study of general security.

That income comes entirely from membership dues.

Incidentally, the premium income of the companies represented in the association is over $200,000,000 a year which is in excess of the amount that is proposed to appropriate under S. 545.

The purpose of the organization is to assist in the developing of sound economic security and it has done, as I say, extensive research in connection with the cost of social security of various types, including health security. Probably you have seen many of its pamphlets.

The Society does support S. 545.

I should say in opening that it was unfortunate that when S. 545 was first referred to in the public press that there was some indication that the insurance industry would not support it. That is not the fact; the insurance companies are in support of this bill and we support it because we believe that it provides health security with an absolute maximum amount of voluntary effort which to us is important.

Next, we think that it recognizes in the process the need of cooperation between Government and private agencies rather than turning over to the Government the entire problem of health security.

Next, we are in favor of this bill because we think it takes a very rational approach to the problem and bases the grants to States on a basis of need following surveys rather than setting up some very weak measure that would be based on conditions which are presumed to exist rather than that do exist in fact.

The doctor that preceded me brought out that point, I thought, very well.

Next, we support this bill because we think that it provides reasonable aid to the States and it gives an opportunity, as one of the Senators said this morning, for experimentation and growth in the individual States rather than attempting to hand down a program for the National Government.

We think it is important that you should proceed in a reasonable way in this connection. We feel that common sense dictates, if you will, that we should know how much of utopia we can afford before we start entering into any permanent contracts in that connection which we believe some previous measures did propose.

We think that the surveys proposed in this measure will lead to a very sound, long-term policy on the part of the Federal Government, following a natural evolution rather than a revolutionary one, if you will.

We think that this bill is constructive without being radical and we believe that it limits Federal aid to where Federal aid is most needed.

I have noticed in some of the previous testimony that questions have been raised about the means test. Well, frankly, we do not see anything particularly wrong about the means test. The means test is being applied every day in the year in every town or township in this country and is being done, in our opinion, with a great deal of skill and a great deal of discretion, and next we see no way of avoiding the means test without the Government Treasury just becoming a grab bag. It is obviously going to be necessary for a long time to come for a means test to be used in connection with providing food and shelter and clothing and other necessities of life to people.

Senator SMITH. Mr. Mannix, may I interrupt you there? As you read S. 1320, which is the Wagner-Murray-Dingell bill, it seems to me that it means use of the means test automatically there because a man with low income pays less and gets the same service; he is classified there simply because he has a lower income. If you have any other kind of means test you find out what the person's resources are. That automatically classifies him.

He may think it is less of a disgrace. I do not know why anybody thinks it is a disgrace. I know all of my life I have been engaged in various things where I did not get much for them. I did not think it was a disgrace that I did not have as much as my neighbors and I do not see that if certain people are to be qualified for certain benefits why they should feel it is a disgraceful thing. There has been so much hue and cry about the means test, but as I say, the Murray-Wagner-Dingell bill provides that the fellow with the lowest income pays the least and the fellow with the highest income pays the most.

Mr. MANNIX. We agree 100 percent with that, and we are attempting to make exactly the same point. As a matter of fact, various aspects of the Murray-Dingell bill did provide public assistance to those who could not assist themselves and provided for a means test in connection with that.

Senator SMITH. I think it is perfectly proper. I am simply saying it is just as much in that bill as in our bill.

Mr. MANNIX. The only point we are making in this connection is that it is not something to be worried about in connection with S. 545. It is just necessary and we believe a good thing. As I said, the Public Treasury is not going to be a public grab bag.

I believe that S. 545 would tend to eliminate the so-called double standard of medicine where indigent sick are taken care of in public institutions by the people taking care of the private patients.

The proposal to permit the local Government agency to contract various health-insurance plans to take care of the indigent would tend, as we see it, to completely eliminate this so-called double standard of medical service, and tend to put everybody, indigent and self-supporting, in exactly the same category, which we think is desirable.

The insurance companies only see one objection to S. 545 as it is now written and that is that it provides in a number of cases for named nonprofit plans. We believe that if the Federal Government or other governments are going to contract for the health care of their employees, we believe that if local divisions of the Government are going to contract for the care of the indigent, that they ought to contract with nonprofit or mutual plans or mutual insurance companies or stock insurance companies based on the merit of the company rather than based on its organization.

We feel that if nonprofit organization was a guaranty of quality and value, and I do not mean to disparage nonprofit organizations—I spent 25 years of my life connected with nonprofit organizations of various kinds—but we believe if that was an absolute guaranty of quality and value that there would be little other than nonprofit organizations.

We think that the decision as to who the carrier should be in connection with this program should be based solely on merit rather than on its type of organization.

Incidentally, in that connection, while some 30 State medical societies have now set up their own nonprofit medical care plans, there are about six State medical societies that have either decided to work with private insurance carriers or are contemplating doing so.

Incidentally, those societies are the State medical societies of Rhode Island, Connecticut, Illinois, Wisconsin, Minnesota, and Arkansas.

And there are about 12 States where the State medical societies are still undecided as to whether they will establish their own plans or whether they will sponsor a program offered by an existing insurance carrier.

Senator SMITH. Are those societies not supported by public funds? I have difficulty in thinking it would be proper to pay premiums to a profit organization. I do not see how you could justify that. I think the term "nonprofit" is almost essential if we are going to use programs for taking care of people on a large scale and use public funds for that purpose.

Mr. MANNIX. You use public funds, do you not, in dealing with many other agencies where many profit organizations service the Government? When you buy food for the indigent, you deal for the most part with the large food chains of the country and you purchase service from them; or you provide health or clothing and you deal for the most part with corporations engaged in selling for profit. We do not think that any insurance company should make great profit in connection with this, but we do feel, on the other hand, that if an insurance company can render the same care for no more, or for less, that it should receive consideration and it should not be discriminated against, if you will, simply because it happens to be organized for profit.

In other words, we think that the decision should be based on the merit of the case rather than the type of organization. Some of these State medical societies, for instance, have become convinced that private insurance carriers can offer health insurance programs of equal value for less cost than nonprofit plans.

I personally happen to be of that opinion after having spent 18 years with nonprofit hospitals and having spent now 14 years with nonprofit plans.

As a matter of fact, an insurance company can be broad, operated on a broad, Nation-wide basis and it gives it certain advantages from a cost standpoint over the nonprofit local program.

I happen to be connected with a company now, personally, that is actually selling hospital care of greater benefits, including every single benefit that the nonprofit plan does, in the State of Illinois for 20 percent less than the local nonprofit plans.

Now, again, I do not wish to suggest that the nonprofit plans should be disparaged. I have been a part of that field for years.

I do think there are advantages that an insurance company may have that may result in their giving benefits as great or greater for the same or lower cost and I think that can be done and the Government should contract with such agencies, private profit plans and the decision should be based on merit and this bill itself should not limit the local Government agency to dealing with a particular type of organization simply because it is nonprofit.

Incidentally, many of the employees of the Federal Government today, after reviewing the programs offered by nonprofit plans and reviewing the programs offered by insurance companies have chosen the plan offered by the insurance company.

Senator SMITH. I am not questioning that, and I think healthy competition is desirable and I think that is fine; but I am raising a question of whether public funds should be used if we back up any profit-sharing system. You will recall the early life insurance when they had to change to a mutualization and that was very healthy for them; that came about because of the abuses. I concede that your company would not be open to those abuses and probably be more than effective and more efficient. I would not want to minimize that and I would not want to in any way appear not to be in favor of a person insuring and paying for his own insurance and buying the best he can get. I would myself. I just raise the question whether we should put into this bill an authorization to use any public funds for profit institutions of any sort.

I do not want to labor the point.

Mr. MANNIX. I do not think you should do that, Senator; I am wondering whether you should not leave that question open.

Senator SMITH. That is a fair question for the committee to consider; but I am just raising the point because as you talk, and apparently speaking in behalf of the commercial insurance companies, it would be proper for you to do so. We would be glad for you to do so. I bring out whether we ought to use public funds, and apparently you think that is the thing to do if service was comparable or better——

Mr. MANNIX. And cost the same or less. The only thing is that I do not think the bill should be so drafted as to restrict local government in planning and I do not think nonprofit organization should be specified but let the local government make its decision based on merit.

In closing, I would just like to repeat that we are very much in favor of the bill as written; and the insurance industry stands, with the exceptions that I made, ready to support it.

Senator SMITH. Are there any further questions?

(No response.)

If there are none, the committee stands adjourned until 9:30 tomorrow morning.

Thank you, Mr. Mannix, for your testimony.

(Whereupon, at 12:45 p. m. the committee adjourned until 9:30 a. m. Thursday, June 26, 1947.)

(Mr. Mannix submitted the following brief:)

STATEMENT OF JOHN R. MANNIX, PRESIDENT, JOHN MARSHALL INSURANCE CO. OF CHICAGO, REPRESENTING THE INSURANCE ECONOMICS SOCIETY OF AMERICA ON S. 545, BEFORE THE HEALTH SUBCOMMITTEE OF THE SENATE LABOR AND PUBLIC WELFARE COMMITTEE

It is unfortunate that the introduction of S. 545 was attended by publicity to the effect that the insurance industry does not favor measures such as this bill proposes. The exact opposite is the case. In behalf of the Insurance Economics Society of America, I wish to report that there is overwhelming insurance support of the purposes of this proposal.

The Insurance Economics Society is composed of nearly 80 company members, chiefly in life, casualty, and accident and health fields, and of between 4,000 and 5,000 individual members.

The company members have an annual premium income exceeding the Federal appropriation for health, hospital, and medical services proposed by this bill; that is, exceeding $200,000,000 annually. Individual members of the society include representatives of the afore-mentioned fields, of fire and marine insurance, and of artivities having no connection with insurance.

Among society participants and contributors are members of such prominent insurance organizations as the American Life Convention, the American Mutual Alliance, the Association of Casualty and Surety Executives, the Bureau of Personal Accident and Health Underwriters, the Health and Accident Underwriters Conference, the Industrial Insurers Conference, the Louisiana Insurers Conference, and so on.

Many individual members also are members of the National Association of Accident and Health Underwriters, the National Association of Insurance Agents, or the National Association of Life Underwriters.

The Insurance Economics Society was established in 1917 to consider the economic aspects of the State health insurance programs contemplated by several of the States at that time. It was active for about 5 years, and then became dormant when interest in State health insurance died. It remained inactive for two decades until 1942, when it was reorganized and restaffed.

Activities of the society have been concentrated on the supporting of independent research in insurance economics and on the distribution of information gained through such research.

Basic objectives of the society have been stated as follows:

1. Our national objective is sound economic security for all. This objective should be obtained by voluntary means as far as possible.

2. There should be greater research and study of the costs and the social, economic, and political effects of compulsory Federal and State insurance, and thorough investigation of alternative ways and means which may be employed with a minimum of governmental compulsion and regimentation of the individual.

Because the society seeks economic security for all with maximum use of voluntary effort, it is obvious from its support of Senate bill 545 that it does not consider the intent of this bill to be antagonistic to the best use of voluntary enterprise. On the other hand, the society's endorsement constitutes rather explicit recognition of the need for cooperative effort involving both governmental and private agencies in achieving "sound economic security for all" in the health field.

This is simply another way of saying that insurance men take a constructive attitude toward the health problems of our country. They believe that their own field—that of insurance—already is doing a great deal to meet these problems by providing reliable means of financing good health care, and they believe that insurance can and will do a great deal more, given reasonable opportunity. They recognize the need for governmental participation in any broadly organized program to serve the needy. They feel that Senate bill 545 sets forth a practical program for governmental action and at the same time is a potential instrument of greater insurance service. Beyond these immediate considerations, they are interested in Senate bill 545 as a proposal having broad implications for our national welfare.

There is neither time nor, I believe, the necessity, for entering into a detailed review of the manner in which the Insurance Economics Society has approached the problem of greater health security for all. The members of this committee undoubtedly have received copies of many of the studies which the society has sponsored or distributed.

It is worthy of particular notice, however, that the society has placed great emphasis on two considerations which have been conspicuously ignored in panacea proposals for the improvement of our national health. The society is interested first in the extent of the actual need for tax-supported programs to improve and extend health services. This is a perfectly logical concern for an insurance-affiliated organization. On the basis of common sense alone, it is obviously wasteful and unsound to plunge into sweeping measures designed to alleviate conditions whose existence is more presumption than known fact. The present proposal—Senate bill 545—does not make this mistake. It requires scientific investigation of the need through surveys, plus definite organization to meet the needs thus determined.

The second consideration which has concerned the society has been that of cost, another item which has been measured almost wholly by guesswork in various corrective proposals submitted previously. Again, common sense suggests that we should know how much of Utopia we can afford before we enter into a permanent contract for its purchase.

In view of the importance of these considerations, Senate bill 545 proposes a rational approach. It admits an obvious need, and it would finance a period of investigation and experimentation as the basis for a permanent program. The need that we may take for granted involves the improvement of health services for the indigent and near indigent. While the indigent are by no means without good health services today, it has become apparent that these services, like many other activities in our increasingly complex society, must be more effectively organized and distributed.

This is properly an area for governmental action. It requires taxation, and government alone has the power to levy taxes. The extent of the necessary taxation is admittedly unknown at present, but the requirement for preliminary surveys gives reasonable assurance that the costs of the program will be based on actual need.

Insurance men, I believe, consider one of the important virtues of Senate bill 545 to be the fact that it is constructive without being radical. It proposes simply that government give help where help is needed. Certainly that is a sensible objective, and certainly it contrasts strongly with the notion that government should force assistance upon that great majority of the people which neither needs nor desires help. In the words of the bill itself, it is intended "to assist the States to provide general health, hospital, and medical services for families and individuals with low income" or "having insufficient income to pay the whole cost of such * * *"

The use of the word "provide" might be questioned. From other sections of the bill it is apparent that the intent is to "assure" adequate health services. In many ways health services are indeed provided by the States, as is the case in tuberculosis and mental institutions or through public health departments, but the actual rendering of health services by private hospitals and doctors also is envisioned in this bill.

Most assuredly, as has been pointed out elsewhere, the programs contemplated through Senate bill 545 will involve the application of "means tests." It is difficult, however, to understand why this should have been cited as an evil. In behalf of applicants for public assistance in a dozen different categories, means tests already are applied daily with skill and discretion by our thousands of social workers. They are essential if our treasuries, both Federal and State, are not to become public grab bags, and we may be sure that they are infinitely more fair than income taxes or percentage assessments against cash income such as that proposed for compulsory national health insurance. Cash receipts during a year are a poor barometer of actual "means" for many millions of our citizens.

Both on the basis of the evidence at hand and because it is in keeping with American tradition and experience, the allocation of responsibility to the States by Senate bill 545 is well conceived. James Madison, who has been called the "master builder" of our Constitution, pointed out that "the powers reserved to the several States" by that document "extend to all the objects which, in the ordinary course of affairs, concern the lives, liberties, and properties of the people and the internal order, improvement, and prosperity of the State." In many ways we have diverged a long way from that simple yet vital concept, and it is to be questioned whether this digression has always resulted in net good. The problem of health care is an excellent case in point.

A recent study by the Research Council for Economic Security points out the enormous variations in the nature, causes, and scope of health problems between States. Even the most superior national administration could not possibly cope with such variations without producing an excess of standardization, a multitude of local inequities and, needless to say, a corresponding host of new reasons for outraged constituents to protest to their Senators and Representatives. Senate bill 545 provides for the means for a great campaign to improve health services to the indigent by stimulating and encouraging action within the States, and it would enable the development of high national standards to which the States individually might aspire.

Insurance men look with particular favor on the provisions in Senate bill 545 which would allow and even encourage private participation in the program to meet the health problems of the poor. While Government alone can levy taxes certainly private organizations can and should assist in the provision of those services to the indigent for which this bill would provide, as has been indicated. Specifically, I refer to the proposed amendments to the Public Health Service Act (through the addition of titles VII and VII) and title III. The former provide for the purchase of private health insurance for those entitled to aid under the bill; the latter provides for the deduction of insurance premiums from the pay of Federal employees.

Under the first of these there would be great incentive for elimination of much of the so-called double standard of medicine which exists widely today in the provisions of health services to the indigent by Government. The present system commonly brands the poor as the recipients of public assistance, segregates them in charity facilities, and results frequently in mass rather than in individual treatment.

If these same persons were provided with good health insurance and were thereby enabled to select their own hospitals and doctors, they would become indistinguishable from self-supporting insured patients. In the interests of simple justice, this is an advance greatly to be desired.

There is no restriction in Senate bill 545 which insurance men believe should be removed. This would limit both Federal employees and beneficiaries under the bill to the purchase of nonprofit insurance. If nonprofit organization were a guarantee of highest quality or greatest value, there could be no quarrel with this restriction, but we would have little or no profit-making activity in this country today if this were the fact. The merit of the program rather than the nature of its organization clearly should be the sole factor determining its selection or approval by State authority, and certainly the program of highest merit is much more likely to be evolved where there is free competition among organizations of all types. Profit-making insurance asks no concessions—simply an equal opportunity to compete in the development of the program of the highest merit at the lowest cost.

On the whole, Senate bill 545 is worthy in purpose, well considered in approach, and wholly in harmony with the constructive purposes and methods of American democracy. It is for these reasons that it has insurance support.

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NATIONAL HEALTH PROGRAM

THURSDAY, JUNE 26, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room, Capitol Building.

Present: Senators Smith and Donnell (presiding by request of Senator Smith, chairman of the subcommittee).

Senator Donnell. The committee will be in order.

Senator Smith has been unavoidably detained and in view of that fact he has asked me to preside at the session until later on.

Senator Pepper desires it to be stated for the record that because of the trip which has been engaged in by himself and others to Warm Springs, Ga., he will not be able to be present this morning. He will not return to Washington until 1 o'clock this afternoon.

Senator Murray desires to express into the record his regret that he likewise will not be here this morning. He is, as I understand it, on the same mission on which Senator Pepper is engaged, and Senator Murray particularly regrets the fact that he will not be here this morning to hear the testimony of Dr. James C. Shields of the Montana State Medical Society, Butte, Mont. He desires to have his apologies and regrets stated in the record, which I have now done.

Will you come forward, please, Dr. Shields?

STATEMENT OF DR. JAMES C. SHIELDS, THE MONTANA STATE MEDICAL ASSOCIATION AND THE MONTANA PHYSICIANS' SERVICE

Dr. Shields. Mr. Chairman, if the committee will permit, I would like to make two remarks before beginning my formal statement.

Senator Donnell. Very well.

Dr. Shields. First, yesterday before the committee appeared a man of the medical profession much younger in the profession than I. He gave such a splendid analysis of the facts and statistics that I believe as a whole was unknown to the committee and certainly unknown to the medical profession.

I feel that that pamphlet is of such importance it would do well to print it in a separate form that it can be available to the profession and to those who desire it.

Senator DONNELL. You are referring to Dr. Friedman, are you?

Dr. SHIELDS. To Dr. Friedman of Washington, D. C. I certainly congratulate him and extend my compliments.

One other remark I would like to make, and that is this: Senator, coming from the heart of the Rockies, on this long trip down here, I doubted very much and had misgivings that I should not be here, that it was a waste of my time and a waste of the committee's time.

After arriving and meeting a townsman of Montana and of Butte, and having been received so cordially that I feel at home, I feel that it is a duty that Montana owes to the committee.

Senator DONNELL. Doctor, I appreciate both of your points. In regard to the matter of the printing of the statements of Dr. Friedman, that matter will be considered by the committee and I am sure it will consider in that connection your advocacy of printing the statement as a separate document. I am unable to state what will be the ultimate decision of the committee on that matter, but we very much appreciate your thoughtfulness and your suggestion and we are likewise pleased that you have found so cordial a reception here and we are glad you are here before us this morning.

Dr. SHIELDS. I wish to extend my heartfelt gratitude to Senator Murray and to the members of the committee.

I will proceed with this statement.

My name is James C. Shields. I am a physician and surgeon in active practice in Butte, Mont. I am past president of the Montana State Medical Association, and Treasurer of the Montana Physicians' Service, a voluntary, nonprofit corporation, which was organized and is owned by the medical profession of Montana.

Senator DONNELL. Pardon me, Dr. Shields; I think I was also informed by Senator Smith that it was the hope of the Senator, perhaps request—I am not sure of that—that Senator Murray hoped that your testimony be not given until this afternoon. It happens, however, that other matters this afternoon which engage the attention of the Senator make it, in the opinion of the present presiding officer, at any rate, impractical to vary from our program and consequently we are going ahead with your testimony although Senator Murray regrets his inability to be here.

Dr. SHIELDS. I am a member of the Silver Bow County Medical Society, the Montana State Medical Association, a fellow of the American Medical Association, a fellow of the International College of Surgeons and a fellow of the American College of Surgeons.

In extent, Montana is the third largest State in the Union, with a population of approximately 550,000. The State has a terrain of wide open spaces traversed by many mountain ranges, and it is a difficult matter to contact all of the doctors on short notice. As president-elect, as president, and as chairman of the public relations committee of the Montana State Medical Association, and treasurer of the Montana Physicians' Service, I have visited every county medical society several times, except two which I have visited only once.

For the last 8 years medical legislation and compulsory prepayment of medical bills have been discussed at every State medical meeting held in Montana. In all these years, I know of but one doctor in the State who favored compulsory prepayment of medical bills.

In order to get the sentiment of the doctors on Senate bill 545, our president, Dr. M. A. Shillington, invited physicians from Butte, Missoula, Glendive, Billings, Great Falls, Lewistown, Miles City, and Helena to an all-day conference in Glendive, Mont., May 18, 1947. With the physicians from these areas, our president discussed in detail every title and section of Senate bill 545. That which I have to say is the unanimous opinion of those present and represents the sentiment of the medical profession of the State of Montana.

Senate bill 545 is a sane approach to the national problem of sickness and health. As a whole, this bill would bring about constructive legislation. It would make each Federal bureau dealing with sickness and health a component part of the proposed National Health Agency, this Agency to be directed by a doctor of medicine appointed by the President, with the consent of the Senate. The Montana State Medical Association stands as a proponent of this portion of the bill, and desires to see its enactment.

We doctors see this problem of sickness and health in a way no one else can possibly see it. It is not only our daily work, it is our life's vocation. We watch the clock for one reason only, to be on time to repair broken and diseased bodies, and to save human lives.

Every masterpiece in any line of human endeavor represents long hours of thought and toil. In business, in industry, in the sciences, arts, and literature, the same holds true. America is great because of the initiative and enterprise of thousands of individuals laboring under freedom—to invent, discover, or produce that which will benefit mankind, and in so doing, benefit themselves.

We all rejoice that thousands reap success, and each of us in turn shares in this new-made wealth.

The American medical system was the glory and one of the humane wonders of World War II. This medical system was not conceived, developed, or directed by the State. It was a natural growth under a government of free men and free enterprise, due to the initiative of the doctors of America. For generations it has been the determination and the ambition of the doctors to make American medicine one of the outstanding achievements of all human endeavor. American medicine, in all probability, gives more free service to those individuals in need than do the medical systems of foreign lands, which impose a tax in order to deliver the service.

We must remember that down through the ages, it was the priest and the physician who were the social workers. This is true today. One does not consult a doctor of medicine if he wishes to draw up a will. One goes to an attorney. Neither does one consult a lawyer if one wishes to build a house. One goes to an architect. Yet, there are those who think it is not necessary to consult the doctors on any problem related to medical care. They believe that the legislators, the social welfare workers, and other laymen can draw up a complete program, have it adopted, and then expect the doctors to make it work.

We must remember, no matter what system is eventually evolved in this country for the delivery of medical care, the doctor must deliver that care. It cannot possibly be delivered by a "social uplifter." Hence, it would be better for all concerned if the plan adopted be one which will enlist the cooperation and the enthusiasm of the medical profession.

The doctors of Montana are of the opinion that the framers of Senate bill 545 are cognizant of, or have sensed, the foregoing factors. Senate bill 545 will give aid to those in need without making them wards of the State. In like manner, it will assist the doctor without dominating and directing him.

We wish it distinctly understood that Senate bill 545 does not appeal to us as stopgap legislation, a bill to accept in order to prevent a less desirable bill from being adopted. We do not favor stopgap legislation. We are not of the opinion that this bill can in any way prevent bureaucratic legislation being introduced and accepted later. Our desire to see this bill enacted is genuine and is based upon the advantages which this bill will give the people of the United States. This is a bill with which the physicians can cooperate. Senate bill 545 is the first bill which in a large measure follows the "10-point program" of the American Medical Association.

We wish at this time to take the liberty of calling your attention to those portions of the bill which we feel might be misunderstood or improved.

In section 102 (a) we find the purpose of the Agency is to promote the general welfare of the people by aiding and fostering progress in the field of health and medicine. Certain portions of this bill are definitely progressive. The bill takes control of the Food and Drug Administration, recommends periodic examination of school children, directs attention to water pollution, and provides certain statistical studies of the health of the Nation. These are all worth while, and each will accomplish some good. We should also remember that the two most important factors which have bearing on health are economic and genetic.

To quote from section 102 (b), sentence 1, we find the phrase "to encourage the development of health services and facilities." We assume this means clinical services. In many paragraphs of this bill, the words "health service" are used where we feel the framers of the bill intended "care of the sick."

Section 102 (b) 3, gives the Administrator, and his assistants, a wonderful opportunity to make available to the people of this Nation information as to the quality of medical care they receive as compared with that which is being given in foreign countries under the compulsory prepayment plans of medical service.

Section 102 (c) 4, transfers to the agency the Food and Drug Administration. We suggest an additional function for the agency in protecting the national health would be some control over the advertising in the press and over the radio regarding foods and drugs in regard to diagnosis and treatment.

Section 203 provides $10,000,000 for the next fiscal year for the prevention and control of cancer. At the present time, the secret of cancer control is early examination and accurate diagnosis. As you see, this depends on the education of the public. We believe that the scope of section 203 should be enlarged to include many conditions, as rheumatic fever, chronic arthritis, and heart disease. Such sums as may be appropriated should not be given to the Surgeon General of the United States Public Health Service. The United States Public Health Service has ample duties to perform. Such money as may be appropriated for any phase of this work should be under the Director of Medical and Hospital Care Service.

Section 702 establishes a State advisory council which is to include non-Government groups and State agencies. This council may give advice, but has no authority. Would it not be well to give this advisory council some authority?

In section 712 (b) 2 and 4, we find that States may make payments to voluntary, nonprofit insurance funds for individuals unable to pay in whole or in part. This is an excellent provision, but the premium charge would necessarily be based on the risk taken and the period of time covered in order to meet the costs of this program.

This bill would encourage and aid voluntary, nonprofit medical and hospital service plans.

That the committee members may know how the public of the State regards the Montana Physicians' Service and the Blue Cross, you should have before you certain information.

The Montana Physicians' Service began selling medical service September 1, 1946. At the present time, there are 26,990 members enrolled. There have been 411 cancellations since September 1—1½ percent. These are individuals, not contracts. Community and farm groups which have been enrolled to date number seven. The service has never lost a group. The enrollment fee on each contract is $1, while the field cost for each contract is 93 cents. No part of the monthly dues are used for the expense of enrollment. Administrative costs for May 1947 were 17 percent. The premiums have amounted to $113,000, and the fees to physicians $78,000. The organization is entirely solvent. The Montana Blue Cross has approximately 65,000 members.

It might be worth while to call the attention of the committee to Government costs as compared with the costs of private organizations doing identical work.

The Veterans' Bureau in Montana uses 10 employees to do exactly the same paper work that is done by the Montana Physicians' Service with 2 employees.

The doctors of Montana believe that nonprofit, voluntary health and hospital service plans will give the American people better medical and hospital care than can be furnished by any Government-managed compulsory plan. This would be particularly true should this bill be enacted, granting States the right to assist, and subsidize in whole or in part for the care of those who cannot afford to do so.

Voluntary, nonprofit, medical and hospital service plans are being developed on a sound, actuarial basis by men who understand the complex problems of medical and hospital care.

We of Montana, with few reservations, trust that this bill may be enacted into law.

Senator Donnell. Doctor, in your comments on section 102, you state that you find the purpose of the national health agency to be to promote the general welfare of the people by aiding and fostering in the field of health and medicine.

I call your attention also to the fact which you doubtless have observed that the sentence in section 102 (a) continues with the language—

> and by centralizing in the agency the activities of the Federal Government relating to health.

Now, Doctor, do you have a copy of the bill before you?

I would like to know for the record whether you are familiar with two other measures now pending: S. 140, known as the Taft-Fulbright bill, and S. 712, known as the Aiken bill, which call, generally speaking, for the creation of the Department of Health, Education, and Security with three Under Secretaries; the Health Under Secretary, by the way, as I understand it, need not be a doctor of medicine.

Now, I would like to get your idea, Doctor, as to whether you would favor the national health agency as proposed in S. 545, or, in contrast thereto, whether you would favor the creation of a Department of Health, Education, and Security with these three Under Secretaries, and your reasons, if you please, for your preference.

Dr. SHIELDS. I would prefer the establishment of a national health agency at the present time for two reasons: First, I feel that a doctor of medicine should head a health program and that those departments immediately under him that form the component parts of this agency, should each be headed by a doctor of medicine regardless of where it would go, whether it be a Cabinet position or a separate agency, but for the present time, Senator, I feel that a separate agency established until this organization and agency is running and has really functioned for some 3 to 5 or 10 years, then it would be the opinion of us from Montana that it would be in shape to have a doctor of medicine or somebody to head it in the Cabinet as a separate entity.

But we do not feel that at the present time it warrants a Cabinet position and we do feel that it should be headed by doctors of medicine.

Senator DONNELL. I note in the record at this time that the national health agency provided in S. 545 to which the doctor has referred, specifies in subdivision C that the Administrator, who is the officer who is to administer the national health agency, shall be a doctor of medicine, licensed to practice in one or more of the States and outstanding in the field of medicine.

Doctor, have you had occasion as yet to study S. 1320?

Dr. SHIELDS. Yes; I have gone over it, but we have not given it the minute study that we have S. 545. But we have discussed it and gone over it and I have read it twice and some parts of it more times.

Senator DONNELL. Are you prepared to give it your general comment, not particularly on the detail of S. 1320 but on the general theory of that bill—whether or not you favor the theory of compulsory health insurance as set forth in that bill or not?

Dr. SHIELDS. No; I do not, and the Montana Medical Society does not favor compulsory health insurance.

We feel this: I do not want compulsory health insurance as far as I am concerned and the vast majority of people that I have talked with, laymen in unions as well as out of unions in Montana, are not in favor of it.

Senator DONNELL. That is as you see it.

Has the Montana profession of medicine given attention to the general proposition of compulsory health insurance?

Dr. SHIELDS. Yes. Last year, and in fact, as I have stated here, since 1939, at every State medical meeting the health legislation and compulsory prepayment plans have been discussed.

Senator DONNELL. And you say in all these years, these last 8 years you know of, you know but one doctor in Montana who favored compulsory prepayment of medical bills?

Dr. SHIELDS. That one was educated in Europe and was only a naturalized American and his background was all European.

Senator DONNELL. I judge you think that these Montana physicians have had through this intensive discussion of the matter over the last 8 years a reasonable opportunity to become acquainted, if not with all the details, at least with general theories and bases for compulsory health insurance.

Dr. SHIELDS. Yes. Until 3 years—since 1934—I was chairman of what is known as the Montana Medical Association committee, and all of these plans, both in this country and abroad, were studied one after another. The consensus, unanimous, was distinctly against compulsory legislation in regard to health.

It is un-American. It is just foreign to the people of this country.

Senator DONNELL. Did you derive an opinion, from the study to which you referred, as to whether or not in foreign countries the quality of medical service has been improved or depreciated through compulsory medical insurance?

Dr. SHIELDS. As near as we can determine, it has deteriorated. That is, you get a variety of medicine that is neither good nor bad. It is not good; it is just mediocre and that is all.

I might call your attention to what has happened in Germany which is common knowledge to us all. Why is it that here in America, American medicine, as far as world medicine is concerned, is supreme and 40 years ago, as I listened to those who preceded me in the medical profession, it was necessary to go to Germany, Austria, England, in order to acquire proficiency in medicine and surgery? That is not true today. Those countries have gone backward and not forward, while America has steadily advanced under free government.

Senator DONNELL. Doctor, your mention of neither good nor bad a few minutes ago is rather striking illustration, I judge, of what Mr. Crownhart, the secretary of the State Medical Society of Wisconsin, said in his book which was mentioned in the record yesterday, and while this is repetitious, I think it is so appropriate to what you said that I am going to read at this point just a very few sentences into the record. He is referring to a professor and quotes this professor as follows:

> Sickness insurance is a leveling device. It assures the mediocre physician just about the same rewards as he who would give an outstanding service if he were to have time. The incomes tend to be level but that is not all—the tendency over the years is to level the services to something that is neither bad nor good.

I pause there to note the similarity of the language with your own observation. And continuing, Mr. Crownhart says:

> But the incentive is gone and we develop fewer brilliant minds in our teaching centers and America captures the lead in health and methods to regain it.

I judge, Doctor, that the theory expounded by Professor Crownhart, or I should say expounded by the professor and quoted by Mr. Crownhart, is generally the thought you are emphasizing in your testimony?

Dr. SHIELDS. Yes, Senator.

Senator DONNELL. Doctor, have you had occasion to make any investigation as to the experience in New Zealand with reference to compulsory insurance?

Dr. SHIELDS. No; just what I have read. As far as I know, Senator, the cost is steadily climbing. That is my last information. What the outcome is going to be in New Zealand is questionable.

Senator DONNELL. I will place into the record at this time a reprint from the Christian Science Monitor of September 29, 1945, under location line of Wellington, New Zealand, entitled, "Free Medical Care Criticized by New Zealand Hospital Head." The hospital head is Dr. G. M. Smith, medical superintendent of the Hokianga Public Hospital, and his statement is mentioned in this article as "the most powerful attack on the system yet published here."

(The newspaper clipping is as follows:)

FREE MEDICAL CARE CRITICIZED BY NEW ZEALAND HOSPITAL HEAD

[Because proposals for government socialized medicine centering so far in the Wagner-Murray-Dingell bill are being agitated in the United States, the following reports of how the new system of tax-financed, free medical and hospital care is operating in New Zealand are of interest in America.]

(Special to the Christian Science Monitor)

[Reprint from the Christian Science Monitor, September 29, 1945]

WELLINGTON, New Zealand.—New Zealand's system of tax-financed, free medical care has resulted in the debasing of medical practice in this country, vast increases in physicians' earnings, and a decline in their value to the community, it is charged by Dr. G. M. Smith, medical superintendent of Hokianga Public Hospital, in the most powerful attack on the system yet published here.

In a brochure just published, Dr. Smith, who has had long service as head of a large hospital, declares that first results of the plan have been that of every 100 patients who consult a physician today only 25 are able to benefit from his advice, that city physicians now send twice as many patients to hospitals as they did before hospitalization became free and doctors' consultation fees were guaranteed, that the Nation is becoming addicted to the habit of swallowing valueless nostrums from bottles, and that since the great growth of hospitalization there is no efficient control of hospitals, which are publicly financed in this country, and no audit of their results.

Particular criticism is leveled at the operation of the system under which patients may consult any physician as often as they like at a government guaranteed fee of 7s. 6d. (about $1.20 at current exchange rates).

SYSTEM HIT

"The national medical association and the politicians of both parties have gone far to foul the name of the profession to which I have the dishonor to belong," Dr. Smith said. "For us who have entered upon our last professional lap, it does not matter much, but what of our young doctors?

"To the materialistically minded medical student, knowledge, experience, and extra qualifications no longer count. All they need to acquire is great riches, and all some want, I notice, is their license to practice which permits them to collect 7 shillings and 6 penny chits."

Facts gathered by this correspondent confirm the indictment of his profession made by Dr. Smith. On reliable authority, it is learned that the national medical association is aware of—

Racketeering by some physicians who collect fees without even seeing their patients.

Great inflation of the earnings of doctors which are easily concealed from the administration.

BIG SUMS FOR LITTLE WORK

State stimulus of the practice of collecting large sums for little medical work.

Disinclination to take difficult cases.

Use of the system of paying mileage charges to country doctors to make illegal gains.

Under the new set-up, it is disclosed, a number of doctors are depositing signed prescriptions at drug stores where patients call to pick up their medicine. This is largely used in continuing treatment of cases for which prescriptions already have been given.

By this and other methods, some doctors have so stepped up their earnings that they are now on easy street. It is easy for dishonest doctors to conceal their earnings, it is claimed, because while the law provides that the patient will get 7s. 6d. paid for him by the State and while the doctor may not use legal processes to collect any more than that sum, he is able to extract as much more from a patient as the individual is willing to give him.

EXCESSIVE FEES

In these days, when doctors are short and patients many, people pay eagerly because they dread that otherwise the doctor would not answer their calls. These extra earnings of the doctor need not be recorded in his receipts, it is said.

Evidence of the inflation of doctors' earnings is provided by a suburb of the capital city. Before free national medical care, the suburb rubbed along on a visit from a physician three times a week and a district nurse. Today it supports a physician who is known to be earning in excess of £6,000 a year ($19,000).

In another city a public institution used to employ a doctor for periodic check-ups of the inmates and paid him £150 a year. Today the doctor employed makes one visit a week to the institution, looks over the inmates, gets signed claims on the social security fund, and collects £1,200 a year for one afternoon's work a week.

Similarly a physician checking up on 300 children at a summer camp was able to collect £112 for a 2-hour task.

In country regions, doctors are allowed mileage fees. The racket worked here is a simple one. If a doctor should be called to attend a patient who lives 30 miles away, he may, for instance, claim 30 miles out and 30 miles back. But suppose he attended on his way a second patient who is 10 miles from his surgery and a third patient who lives 20 miles away. He may then enter a claim for the first patient 60 miles, the second one 20 miles, and the third one 40 miles, which gives him just double the mileage he has earned.

ABUSES REPORTED

These abuses have been reported to the Health Ministry, doctors declare, but the answer is that income taxes are high and the income tax commissioner gets most of it back. New Zealanders charge that most of those responsible for these practices are nonnative doctors.

Dr. Smith's declaration that physicians now send many more cases to hospitals then in the past is generally supported by medical leaders, who say difficult cases are bypassed just as the Government was warned they would be. In addition, to escape patient pressure, many leading doctors have become specialist consultants, which means they can be seen only at higher fees and no longer will visit patients' homes.

Earlier this year Dr. Douglas Robb, an Auckland surgeon, testified before the Parliamentary Committee on Local Government, as quoted in the Auckland Star:

"It is true that the general medical services of New Zealand are not yet organized at all, but they are admitted by all to be open to abuse, costly, and mediocre. They have been authoritatively condemned in Britain and Canada, and the many recent emissaries from Australia seem convinced that their chief value is as an example of how not to do it.

"Therefore wholehearted reform is inevitable, and will call for adjustments on both Government and professional sides."

On the conclusion of the hearing, Dr. Robb was congratulated by the chairman of the committee for the information he had given it, who said his testimony had been most helpful.

Senator DONNELL. Doctor, are there any comments that you would desire to make, further than what you have made, as to the opinion of the Montana physicians' profession on compulsory insurance, or have you given substantially the views found in your statement?

Dr. SHIELDS. I have covered them briefly in my statement, but the Montana physicians do not believe in compulsion.

We feel it is foreign to our system; it is undemocratic. It does not develop and will not develop the individual doctors. It deprives them of the incentive to advance and, as you remarked a minute ago, is a process of leveling.

The man who is ambitious, who desires to spend a night and a day working and studying and going elsewhere to study, postgraduate work—that is more or less taken out of it and when you have a system that those benefits can be given or withheld either by a committee and particularly in this bill by one man, it is not good, not a good law, and it is not good medicine.

Senator DONNELL. By "this bill" you are referring to S. 1320?

Dr. SHIELDS. To S. 1320.

Senator DONNELL. And the man to whom you are referring is who?

Dr. SHIELDS. The Administrator of the Federal Social Security Administration.

Senator DONNELL. The Federal Security Administrator?

Dr. SHIELDS. Yes.

Senator DONNELL. You are familiar with the fact that there is no requirement of law that he be a doctor, and that the present occupant is not a doctor?

Dr. SHIELDS. Not a doctor, but even if he were a doctor, I feel this, and so does the Montana Medical Association—that there is no man big enough to say when medicine should be withheld, those privileges of medicine or when they should be given.

You know, you and I, under what you may term the natural law, have an obligation to take care of our health and take care of the health of those under us.

But we also have a choice. S. 1320 takes that choice away from you and makes that compulsory.

You know, I feel, and so do the Montana Medical Association feel, that our whole theory of government takes its origin in the preamble of the Declaration of Independence, and in a few words it lays the foundation and it is really the soul, we think, of American democracy. It is from the Declaration that the Constitution and the Bill of Rights proceed.

First of all, it affirms, perhaps in so stating logically it is not quite correct, but it was well enough believed and well enough known that Jefferson, when he wrote it, took it for granted and the people of the American Colonies at that time took those things for granted—and first of all were created—we have a Creator, a God, and in creating us he endowed us with a tremendous importance over and above all the rest of creation by giving us rights, the right to live, the right to liberty and freedom, and if you have liberty and freedom it necessarily implies that you must have the right to justice.

That is all based on natural law, and the natural law protects you and me, and, while it is compulsion, at the same time it gives us a free choice to choose that which we think is preferable.

If I have carious teeth, nobody can insist they be pulled if I do not want them extracted. If I have a bad appendix, there is no law that is going to have my appendix removed if I do not want it removed; and then, over and above that, while life is important, very important, we still have the matter of choice.

In certain cases you may give your life to save the life of a friend. You may sacrifice your health in order to save the health of your family. Those are things that are sacred and I do not feel that the Government should interfere in that which is most sacred to you, to me, and to all others, and in that preamble to the Declaration—the Declaration of Independence—there is no human creature so poor, so unknown, but that he has still those same rights; we are all equal as regards those rights, but in everything else we are entirely unequal.

Senator DONNELL. Now, Doctor, I just want to ask you one other question, one or two very brief questions. One of them is, How many doctors are there in Montana?

Dr. SHIELDS. I cannot tell you exactly, but there are approximately 500 at the present time. During the war we were down to 296. But at this time there are approximately 500. We run somewhere between—about an average of 550 for the last 10 or 15 years, except the war years.

Senator DONNELL. I suppose a good many of the 500 consists of those that have come back from the wars?

Dr. SHIELDS. Yes.

Senator DONNELL. Some of those undoubtedly were in England, I suppose?

Dr. SHIELDS. Oh, yes.

Senator DONNELL. Some in France?

Dr. SHIELDS. Yes.

Senator DONNELL. And yet after they have been over there, come back, and come together here, at least the meeting was held that you refer to between physicians of these various sections, there is still only 1 doctor out of the 500 that favors—that you know of—that favors compulsory prepayment of medical bills.

Dr. SHIELDS. Yes.

Senator DONNELL. One other question and I close questioning of you, and that is as to your own practical experience. We have all types of witnesses on subjects of this kind, and they are all of value to us, but we would like to know this: You say that you are a physician and surgeon in active practice. Have you been practicing a good many years, and, if so, how long?

Dr. SHIELDS. I have been in Butte, practicing since October 1917.

Senator DONNELL. Thirty years, or almost 30 years. And where was your preliminary training?

Dr. SHIELDS. My preliminary training was St. Louis University Medical School. I was educated in St. Louis.

Senator DONNELL. Missouri. [Laughter.]

And the general nature of your practice over these 30 years has been office practice solely, or spread out over the country, or what?

Dr. SHIELDS. My practice, to a large extent, has been office practice and surgery.

Senator DONNELL. Have you had a great many patients—undoubtedly you have—in that period of years?

Dr. SHIELDS. Yes, Senator.

Senator DONNELL. Doctor, we are very grateful to you for making this long trip and coming here and giving us this testimony; we are appreciative of your doing so; thank you.

I understand that Dr. Beelman, who is scheduled to be the next witness, is not here, but that Dr. Getting is here, Dr. V. A. Getting, secretary-treasurer of the State and Territorial Health Officers' Association.

Is that correct?

Dr. GETTING. That is correct.

STATEMENT OF DR. V. A. GETTING, SECRETARY-TREASURER, THE STATE AND TERRITORIAL HEALTH OFFICERS' ASSOCIATION

Senator DONNELL. Dr. Getting, if you will answer a few questions as to your background: Where do you live?

Dr. GETTING. I live at Boston, Mass., and I am a State officer of that Commonwealth.

Senator DONNELL. How long have you been a State health officer?

Dr. GETTING. For 4 years.

Senator DONNELL. Doctor, would you tell us, generally speaking, the duties of that office?

Dr. GETTING. I am administrator and executive head of the agency expending an income of approximately $8,000,000 and have under me 1,800 employees in 5 institutions and charged with the responsibility of administering the health services for the State.

Senator DONNELL. You testified before the Education and Labor Committee of the United States Senate last year, did you not, Doctor?

Dr. GETTING. That is right, sir.

Senator DONNELL. On S. 1606?

Dr. GETTING. Yes, sir.

Senator DONNELL. Will you proceed with your testimony?

Dr. GETTING. The State health officers have always been concerned about legislation relating to the health of the people of this Nation. We appreciate this opportunity to express our views on so important a subject as the National Health Act of 1947, S. 545. We appear before you representing the State and Territorial Health Officers' Association. Membership is limited entirely to the health officers in direct supervision of the health programs of the States or Territories of the United States. At the present time there are 52 members representing all of the States and Territories. With one exception, all are doctors of medicine and are members of their respective professional organizations. The primary purpose of the association is to express, through their officers, the views of this select group on various matters pertaining to health. In some States these health administrators are appointed directly by the governor as health commissioners; in other States they are appointed by State boards of health and serve as the executive officer and secretary of the board. The health programs they administer vary greatly. Some State health agencies have several thousand employees, expend millions of dollars in State funds, and administer both preventive and curative medical programs. Others are small and limited in both personnel and funds; however, all carry on, to some extent, the same types of activities and have somewhat similar responsibilities and organizational patterns.

For example, the majority of State health agencies have had years of experience in the control of communicable diseases, environmental sanitation, food sanitation, registration and interpretation of vital statistics, laboratory services, maternal and child-health programs, intensive programs in the control of the venereal diseases and tuberculosis and cancer, together with broad health educational and promotional programs. In recent years, programs have been started in industrial hygiene, cancer control, dental hygiene, mental health and, of late, survey and construction of hospital facilities.

The majority of State and local health departments or agencies were started less than 75 years ago. A careful analysis of the factors active in the increasing length of life of the American people will reveal that the health programs started and carried on through the years by State and local health agencies were dominant in increasing the expectancy for life. In that time the 10 leading causes of death, which encompass from 75 to 80 percent of all deaths, have changed greatly. Germ-borne diseases, which were the leading causes of death in the United States 50 years ago and were considered an inseparable part of our environment, have been greatly reduced and, in the course of time, may be completely eradicated. A typical example is the reduction of tuberculosis. Today we can look with confidence into the future and know that this great scourge of mankind can be eradicated. Reduction in deaths from germ-borne diseases have projected into prominence other disease conditions. Heart disease, cancer, diseases of the vascular system, and nephritis, the first four leading causes of death, today can only be reduced through early detection of normal to pathological tissue changes.

This means that our health programs must start with the apparently normal, well individual. Greater emphasis must be placed upon diagnosis; improved diagnostic techniques, equipment, and facilities must be provided. The conditioning of well persons, to take advantage of all modern scientific medicine, is a long-range, educational job. Once pathology has been established in normal tissues, and has run its usual course in these four leading causes of death, provision of all the medical care in the world will not save from death this large group of our population. Compulsory, national medical care programs are not the answer. In our opinion, death from these diseases knocks just as often at the door of the rich as at the poor. Dr. Louis Dublin, statistician of the Metropolitan Life Insurance Co., in a recent study of deaths of physicians, finds that they vary directly as the general population death rates of given areas. For example, the general population death rates are lowest in the area comprised of Kansas, Nebraska, South Dakota, North Dakota, Minnesota, and Missouri, which has also the lowest death rate among physicians, in each State, quite a list of them.

The Southeastern States have the highest general population death rate, and there also is found the highest death rate of physicians.

Senator DONNELL. Which you said has always been confined to the last State?

Dr. GETTING. The whole group sir; no preference for Missouri.

In heart disease, the leading cause of death, the death rate among physicians is greater than in the general population. The physician, of all of our people, does have available the best possible medical care. He has easy access to diagnostic and hospital facilities, yet the death rate of the physician varies directly as the death rate of the people in the area in which he lives.

Accidents, the fifth cause of death, should not be overlooked. Many are preventable and thought must be given to programs aimed at their reduction. Persons affected with diabetes, tuberculosis, prematurity of infants, degenerative tissue changes of the aged, the leading causes of death, need more than medical care; they can be saved only through early diagnosis and prevention. Likewise, the leading causes of illness today, starting with the common cold and upper respiratory diseases—measles, mumps, mental diseases, and others—need, as yet, a great deal of research.

We assume that behind any national health act is the desire of the authors to reduce, insofar as possible, the preventable deaths, illnesses, and suffering of our population, as well as to promote and maintain optimum health. S. 545 is the first congressional medical-care bill proposed, in our opinion, that so far lends itself to those objectives, after amended. However, the State health officers feel that any legislation that will substitute an unknown, nationally controlled system of compulsory medical care for any segment of our population to the present pattern of medical service may jeopardize the well-being of the American people unless it is well integrated with existing facilities. Our present system is wholly democratic in its organization and service. The general health of our people, in terms of mortality and morbidity rates, improved during the war, in spite of the shortage of physicians and hospital beds. The natural growth of medical knowledge and evolution of the medical profession in its inherent, continuous struggle to improve its techniques and individual skills promises even greater benefits to humanity. The commitment of the American Medical Association, which represents the majority of medical physicians, to the broad health program, as outlined in 10 major items, should be considered by this committee. The principles advocated could serve well as a guide in the preparation of Federal legislation aimed at improving the health of the Nation.

Let us not be hasty in dealing with the lives and health of our people. Medical-care surveys and studies as recommended in S. 545 are necessary if we are to intelligently deal with this complex problem. Surveys, studies, and interpretation of the material accumulated and the preparing of a sound health program can only be done with the assistance of trained physicians having complete knowledge and experience with the factors influencing life and health and with the wholehearted cooperation of the general practitioners found in every community, and upon whose shoulders the entire program must finally rest.

Taking up title I, which deals with organization, in our testimony presented on hearings on S. 140 and S. 712, held before the Senate Committee on Expenditures, we indicated that the State and Territorial health officers were in favor of the organization of, first, a National Department of Health under the direction of a Cabinet member or Secretary, who would presumably be a physician trained and experienced in the administrative aspects of public health and medical services.

Senator DONNELL. May I interrupt you right there? Under the terms of S. 140 and S. 712, am I correct in the statement that three Under Secretaries are contemplated, one of whom would be Under Secretary for Health and there is no requirement in those measures that the Under Secretary be a physician?

Dr. GETTING. I believe that is correct, Senator Donnell.

Senator DONNELL. Thank you.

Dr. GETTING. We also indicated that we feel, under the present structure of the Federal Government, there was little chance of the creation of a separate Department of Health and we, therefore, as a second choice, supported the creation of a combined Department of Health, Education, and Security, and presented an amended bill for S. 712 which would, in effect, create such a Department of Health, Education, and Security.

The State and Territorial health officers are not convinced that the creation of a National Health Agency, as proposed in this bill, is conducive to the most efficient and economical administration of a national health program.

In analyzing this bill, the association concluded that the organization of the National Health Agency, as set forth, has several shortcomings which may be summarized as follows:

(*a*) The National Health Agency, as proposed, is not a Department with a Cabinet Secretary at its head.

Senator DONNELL. By this bill you refer to S. 545?

Dr. GETTING. Yes, sir.

(*b*) The Administrator of the National Health Agency is required to be a physician licensed to practice medicine in one or more States. It is our conviction that if there is to be a physician at the head of such an agency, he should have had at least a minimum of 5 years of full-time health and medical administrative experience. We have seen numerous examples where excellent clinicians or teachers in medical school have made extremely poor medical administrators.

(*c*) The bill provides that the Director of the Medical and Hospital Care Service shall be a doctor of medicine, licensed to practice medicine in one or more States, who has had at least 5 years of active medical practice and who is outstanding in the field of medicine. Here again, we have the same criticism. A Director should be a physician who is not only licensed to practice medicine, but who has had at least 5 years of full-time health and medical administrative experience of a responsibility and size which would warrant his competence to the position of Director of such an important organization. A clinician or outstanding physician of 5 years' practice in any of the specialties of medicine, while absolutely competent in his own field, would not, in our opinion, be acceptable qualifications for this position.

(*d*) The United States Public Health Service is an old, well-established governmental agency. It has been cooperating with State departments for more than half a century. At present, it is the strongest, most acceptable agency at the national level administering Federal health programs. Through the years, its general policies have been to promote State and community responsibility for all health programs. Unlike many other activities carried on by Federal agencies, with offices in each State, public health, today, following that long period of cooperation, is entirely in the hands of State and local administrative officials. There has been much confusion on this point, and it is misunderstood by both professional and political groups. When a State elects to accept grants-in-aid funds for a given health activity, both the funds and the responsibility for the program are in the hands of State and local health officials, as long as certain rules and regulations are followed With all its faults, the United States Public Health Service is in a position to be reorganized, strengthened and made the nucleus of a health agency, able to resist the many and varied pressures from all sources, as they may develop to weaken the effectiveness of national health programs.

We recommend that, in the creation of a National Health Agency, if one is to be created, serious thought and consideration be given to its development about an existing organizational set-up, which has already proved itself to be experienced, efficient, and economical in the administration of public health. This organization is the United States Public Health Service, and the formation of the new agency can be developed about this organization

It is further suggested that efforts should be directed toward making this agency a department, with a Cabinet health officer at its head, who shall have the usual authority and powers of any Cabinet officer in the administration of his own department. The specification that the agency shall have various constituent units; namely, the Office of Administration, Office of Public Health, Office of Medical and Hospital Care Services, Office of Dental Care Service, et cetera, makes it incumbent upon the Administrator to form such units, without giving him an opportunity to study the organization of the department, and form such units as his study and investigation will reveal to be best suited for the efficient administration of the national health program. Moreover, the authority vested in the proposed administrator of this National Health Agency is vague and uncertain. To him is transferred some of the authority now vested in the United States Public Health Service and the Surgeon General. Likewise, to him are turned over some of the responsibiilties now vested in the Administrator of the Federal Security Agency. However, the responsibilities more recently given the Federal Security Administrator in the President's Reorganization Plan No. 2, and with the passage of Public Law 725, are not assigned to anyone in the new Health Agency, but would remain apparently with the Administrator of the Federal Security Agency.

It is necessary, therefore, to review carefully not only the organization of the National Health Agency, but to carefully integrate the United States Public Health Service and use this as the nucleus in the formation of such an agency, and to review carefully the authority and responsibilities assigned to the administrator of such an agency. If the Federal Department of Health, Education, and Security is formed, it is still the recommendation of the State and Territorial health officers that the Surgeon General be the head of the Health Division and that the administration of medical care programs be carefully integrated under his direction. In our considered judgment the provisions of title I, section 102, on pages 3 through 6, are not so designed as to take advantage of existing facilities already efficiently operating. Thus, the simplified and economical administration of health programs, which the United States Public Health Service, in cooperation with State health agencies, has so ably carried on would be lost. Instead, there would be a cumbersome and unwieldy, costly superstructure imposed upon the existing organization, with some substantial duplication of administrative facilities, without proper control of these various divisions by the administrator of the agency.

It is, therefore, our recommendation that the administrator of the agency be given authority to reorganize such divisions and bureaus in the department as, after study and investigation of a year or more, he finds best suited to meet the needs of the Nation. Sections 103 and

104, on pages 6 through 10, should, therefore, be revised to permit such discretion on the part of the administrator. The State and Territorial health officers are in sympathy with section 108, on pages 11 through 12, calling for a study to be made of the Commission Corps of the United States Public Health Service. We feel, however, that no time limit should be put upon such a study and that the study should be designed toward the end that more effective means would be developed for attracting qualified, trained and experienced personnel of all professional categories to the United States Public Health Service. The present shortage of public health personnel is all but catastrophic, not only in the State health departments, but it is also seriously affecting the United States Public Health Service. Serious thought and consideration must be given to protect the public health of the Nation, by making positions in State and Federal health departments more attractive to qualified personnel.

In regard to title II, amendments to Public Health Service Act, the old adages, "a stitch in time saves nine" and "an ounce of prevention is worth a pound of cure," are apt in opening discussion of title II of the National Health Act of 1947. The State and Territorial health officers are convinced that the Government must provide total coverage to the Nation with adequately staffed, full-time local health departments, in order to assure the availability to all of the people of the Nation the benefits of preventive medicine before we attempt to administer Government medical care programs of any kind in these same areas. At the present time, approximately 40,000,000 people are living in areas without the benefit of services rendered by local health departments. It is imperative, therefore, that amendments to the Public Health Service Act provide increased funds to be used for general health purposes. Such funds as grants-in-aid to States should be sufficiently large to enable the States to subsidize local units of government on a matching basis, so that all of the people would receive the benefits of public health. To these services we might add the administration of medical care programs.

It is our conviction that such services as maternal and child health, school health services, the control of communicable diseases, special provision for tuberculosis, venereal diseases, cancer and chronic diseases, laboratory diagnosis, nutrition, health education, vital statistics, medical social work, and other accepted functions of public health agencies are a means of preserving the health of the Nation. Without these services we cannot efficiently or economically administer a medical care program. Our primary objective should be the maintenance of good health and the prevention of illness. After all preventive measures, which are possible in the light of present knowledge, have been applied, there will be an inevitable residual of sickness. It is for the provision of medical and hospital care of these ill persons that a medical care program is needed. Certainly, it would be foolhardy to embark upon a medical care program, without making every effort to reduce illness to an absolute minimum. It is, therefore, the recommendation of the State and Territorial health officers that section 314 (c) of Public Law 410 of the Seventy-eighth Congress be amended so as to make available to the States and Territories additional sums for the provision of local health services to all people.

Our association endorses the cancer program as outlined in section 203 by making Federal grants-in-aid available to the States for this purpose. Since cancer is the second leading cause of death in our population, the ceiling on the amount of Federal funds should be raised so as to enable the several States to carry on adequate cancer-control programs, including diagnosis and treatment. The provision of only $10,000,000 for its control is entirely inadequate for the size of the problem.

Title VII bears the heading "General medical service for families and individuals with low income." The association approves in part the survey of facilities, the determination of need, and the formation of plans to meet such needs as proposed in part A, entitled "Medical Care Survey." This part is modeled after a similar part of the Hospital Survey and Construction Act, Public Law 725 of the Seventy-ninth Congress. This survey should, of course, be integrated with that required by the Hospital and Health Center Construction Act, and should include public health as well as medical care facilities. If $3,000,000 are required to make a survey of hospital facilities, there is some question in our minds as to why a similar amount of $3,000,000, as provided in part A, is sufficient to carry on such a survey over a period of years. It is, therefore, our recommendation that the sum of $3,000,000 either be increased or that section 701 be so amended as to make possible further appropriations at a later date.

Part B: The State and Territorial health officers are concerned with part B, Medical Care Service, in that this section limits the scope of the medical care program in a very serious way. The State and Territorial health officers are convinced that, if the Government is to sponsor a medical care program, such a program shall be designed as flexible as possible to permit States to adapt the program to their needs. Because of the limitation of the program to "families and individuals with low income," it would be impossible for any State to expand this program to include other segments of the population should it desire to do so. A single medical care program would not only be more efficient and economical, but would be more receptive to the general public and be of infinitely greater service to it. The definition of low income apparently is to be decided by the various States. If data of the Department of Labor is to be accepted, in 1941, 65 percent of all families and single consumers had total annual incomes below $2,000; 85 percent had incomes below $3,000; and 95 percent, incomes below $5,000. Certainly, there is a decided difference of opinion among all authorities, economists, medical, public health, and others, as to what might be defined as a low income. Studies conducted by the Committee on the Cost of Medical Care in 1928 to 1931, and of the United States Department of Agriculture, have revealed that the lack of provision of medical care is not limited in any way to the lowest income group.

For these reasons, the Association of State and Territorial Health Officers reaffirms its suggestion that States be permitted, after study and investigation, to fit this medical care program to the segments of population as may, in their opinion, be in need of such services. It is our conviction that separation of the medical care program for those who are indigent and those who are not indigent, may lead to a differentiation in quality of services rendered. The use of the term, "low income," also presents the aspect of charity and the means test. Americans believe in the dignity and self-respect of the individual and the integrity of the family. We have our pride and are anxious to maintain our self-respect. We are reluctant to receive the alms of charity or welfare and are anxious to avoid so-called financial investigations to determine our eligibility for charity purposes. For these reasons, we feel that the State, rather than the Federal Government, should determine whether or not a medical care program should be made available to all of the people or a certain portion of them. The State, after conferring with the public and with the professions rendering services—I would like to underline "after conferring with the public and with the professions rendering services"—can establish a program which might, after a period of experience, be changed from time to time to meet the requirements of the population.

Moreover, the provision of $200,000,000 a year, to be matched by the States on an average of a dollar-for-dollar basis, making a total sum of $400,000,000 available for the provision of medical care, is inadequate to meet the size of the problem. It would be foolhardy to expect $400,000,000 to even scratch the surface, since approximately 4 to 5 billion dollars are now being expended by all agencies combined for the provision of medical care. Thus, only approximately 8 to 10 percent of the population could be afforded medical care by the use of $400,000,000. Obviously, if this is to be a national health program, the limitation of the appropriation to $200,000,000 a year is inconsistent. The association, therefore, recommends that, after the first year, legislation authorize such sums as may be necessary, and States wishing to do so, could use these Federal funds for the establishment of well-integrated, comprehensive programs, without resorting to definitions of low income which might be subject to Supreme Court review; that States be permitted to provide for such widespread medical care programs as care of the chronically ill, the improvement of diagnostic and therapeutic facilities designed for all types of illness, in general, special or chronic disease hospitals, in convalescent nursing homes or in custodial institutions.

The State and Territorial health officers are somewhat concerned about the dollar for dollar matching requirement imposed upon all of the States in an equal ratio. While many wealthy States would thus receive a greater proportion of return from the Federal Government, we acknowledge that there are parts of the country which could not adequately meet such a matching formula. We believe that a variable matching ratio might well be utilized in this program, provided that this variable ratio is based upon a sound administrative formula. The States realize that, because of the more rapid means of transportation and because of the increasing exchange of populations between the States, the health of any one State is affected by the health of all the individual States and, for these reasons, the health officers of the more prosperous States feel that the Federal Government should make due allowance for those States which have a less favorable economic status.

Section 715 provides for the organization of a National Medical Care Council. It is the opinion of the State and Territorial health officers that the establishment of a National Health Council would be highly desirable, that such a council should advise the National Health

Agency in its total program, and that such a council should have only a general advisory function. It is the recommendation of the association that, instead of a National Medical Care Council, a National Health Council be established in which would be combined functions of the various councils outlined in this bill.

It would be desirable to increase membership of this National Health Council to include representatives of the various professional groups interested as well as the public. It would likewise be desirable to give the public a greater voice in the National Health Council than is contained in the National Medical Care Council as defined by section 715. The council should be given the right and the facilities to make public their recommendations. Such a council should have strictly advisory functions and not be given administrative or executive authority. The council might well have committees devoted to special fields. Membership on such committees would not necessarily have to be limited to members of the council. The administration of the funds of the program, as delegated by Congress, should be the responsibility of the proposed health administrator and his staff.

A review of the provisions of title VII, section 711, indicates that there is no provision for supplementary laboratory, diagnostic or nursing services, or the prescribed medicines and appliances which are necessary if an adequate medical care program of high quality is to be rendered. States are authorized to make agreements for buying services from voluntary medical programs. Such medical care would be limited in many States, since most States' voluntary medical care programs are limited to hospitalization and medical and surgical care in the hospitals. In these States provision should be made for home and office care. Section 712 (4) (b), line 24 on page 18 through line 2 on page 19, reads as follows:

> Such program shall provide for the collection of proper charges of less than the total cost of such services from persons unable to pay in whole but able to pay in part therefor.

This imposes an extremely costly administrative machinery upon the State agency. We have determined, for example, that, in the rendering of dental care to school children, the investigation by the medical social worker, in order to determine ability to pay, would impose a greater cost for each person served than the services rendered. In Massachusetts, in regard to the distribution of plasma and whole blood and other fractions of blood, we determined that, in order to collect approximately $15,000 from those who could afford to pay in whole or in part for these products, we would have to spend a sum of $10,000 to set up the necessary administrative machinery. In addition to this costly machinery, there would be placed a certain stigma upon those who had services on a charitable basis. The State and Territorial health officers do not approve the requirement either in this medical-service program or subsequently in the dental-service program as required on page 31, section 812 (4), lines 22–25, and page 32, line 1. We do not believe that collection of relatively small amounts of money would in any way justify the additional administrative cost. In addition, many who should receive medical care or dental care under this program would be reluctant to seek it for fear they might be labeled as recipients of charity. The State and Territorial health officers, therefore, recommend the deletion of the word "shall", in line 24 on page 18, and substitute therein the word "may." We also recommend the provision of supplementary laboratory and diagnostic services, bedside and public-health nursing, and the supplying of expensive drugs and appliances when necessary.

The subject of title VIII is Dental Health Services for School Children and Families and Individuals with Low Income. The Association of State and Territorial Health Officers endorses, in principle, the dental health services for school children and for the segment of population as might in the judgment of the State be entitled to such services.

Part A: A dental survey should, in our opinion, be integrated with the original survey as provided by title VII, part A. An over-all survey of public-health and medical-care facilities should include all of the facilities in a State intended to maintain or improve the health and take care of the sick. Therefore, it is our suggestion that section 801 be integrated with section 701.

Part B. Dental-care services: All school children need some dental care each year. Although the annual inspection may screen out those who need more extensive remedial or corrective services, and, in addition, may focus the spotlight of public attention on the great amount of dental caries which might be prevented, such routine examinations should not be required annually. Certainly, the reports on physical examination of men under selective service indicates, to some extent, the need for broad dental-health services for children. The State should be permitted to determine, in its judgment, after proper advice of the public and those rendering the services, as to the content and scope of the dental program it wishes to develop. Dental care should be extended to all those who cannot obtain such services.

The State and Territorial health officers favor the extension of dental services to all school children, regardless of income, and to such segments of the adult population as may be determined in the opinion of the State to be desirable without limitation or prescribing of the content of the program except for the setting of minimum standards by the national agency. The provision of a National Dental Health Council is again best integrated in the over-all Advisory Health Council previously recommended. A subcommittee might devote its attention to dental health. We do not believe that it is necessary to set up a separate National Dental Health Council. Moreover, such a national health council, as explained before, and its subcommittee should be purely advisory with no administrative or executive authority.

Titles VII and VIII are combined. The Association of State and Territorial Health Officers believes that grants-in-aid from the Federal Government to the several States should be channeled through a single office, preferably the United States Public Health Service, and a single plan and budget and report be required for the complete coverage of all.

The setting up of multiple divisions with authority to approve plans is not conducive to consolidation and coordination of Federal and State health programs. We believe that the Federal agency should have authority to set minimum standards in the technical aspects of the program, and to require that all personnel employed meet certain minimum standards as might be set up in State merit systems. We therefore recommend that the United States Public Health Service be authorized to set minimum standards as to content of program, and to require that persons employed meet the requirements of State merit systems, and that all regulations pertaining to the administration of these programs be presented to a conference of the State and Territorial health officers prior to their enforcement, and that advice and approval whenever possible be obtained from the State and Territorial health officers in advance. It is necessary that the States be furnished as complete freedom as possible for the administration of a health program so as to best meet the needs of their individual populations. The State and Territorial health officers, therefore, approve wholeheartedly the principle of States' rights as exemplified in this bill.

Title IX bears the heading "Further research and training." The Association of State and Territorial Health Officers approves part A, setting up a dental research program, in principle but desires to see the ceiling increased for this purpose. We recommend that no legislative ceiling be placed upon the funds for research within the National Institute of Health, and suggest that the bill authorize such appropriations as may be necessary. The Surgeon General is required under section 903 to turn to the National Dental Health Council for advice relative to research projects or programs. It is suggested that a Dental Health Advisory Council be a subcommittee of the National Health Council, as previously developed in our testimony. Thus the advice from the Dental Advisory Council would channel through the parent organization to the Surgeon General.

Title III: As has already been explained in our testimony, all authorities now vested in the Surgeon General and Federal Security Administrator will not be transferred to the new agency proposed by this bill. A careful review should be made of existing laws to make sure that the administrator of the National Health Agency or the administrator of any proposed Federal Department of Health, Education, and Security is given the necessary authority to administer the laws, such as Public Law 725, and authority now vested in the Federal Security Administrator under the President's Reorganization Plan No. 2.

No provision is made in this 1947 National Health Act for the training of personnel necessary to meet the expansion of public-health and medical-care services envisioned by the act. To meet this need, the State and Territorial health officers recommend: (1) funds to be made available to schools of public health, medical schools, and other professional schools for the training of personnel required for the administering of these programs and for rendering services; (2) funds on a fellowship basis through State health agencies be made available to individuals seeking such training. Such funds should provide for adequate training of physicians, nurses, dentists, and other professional help necessary to implement the administration and rendering of services.

Because of the possibility of epidemics or unpredictable illness, provision must be made in any medical-care program for meeting such contingencies or emergencies as may arise through no fault of any agency. It is therefore suggested that more adequate provision be made in this bill for assisting States in such outbreaks or emergencies as may occur through on act of God, such as hurricanes, floods, and the like. Certainly, States should not bear the entire burden of such unpredictable emergencies, and it is desirable to make provision in this law for complete coverage under such unusual circumstances. This may require amendment to section 307 on pages 46 and 47.

Summary: The State and Territorial health officers support in principle S. 545 and believe it will meet some of the needs of the people for more adequate public-health and medical services. We are, however, suggesting certain changes in the administration of the National Health Agency, primarily the preservation of the United States Public Health Service as an efficient nucleus about which to develop the new agency; the expansion of public-health services so as to reduce illness to a minimum at the same time as we attempt to provide medical care. We are in entire accord with the principle of States' rights and the vast amount of authority which is left with the States in the administration of this program. We suggest, however, that this authority be broadened so that States may make a single, inclusive medical-care program, if they so desire, after advice from the public and professions rendering medical services. The State and Territorial health officers are pleased at the interest the committee has expressed in the expansion of public-health services and in the sympathetic understanding that they have evidenced in the past in meeting the problems for health and medical services. We wish to express our gratitude to the committee for the opportunity to appear before them and represent the State and Territorial health officers, who will be charged with the administration of this program on the State level.

Senator DONNELL. We are very grateful to you for this very comprehensive statement and are pleased to have it. I would like to ask a few questions, if I may.

In the first place, I would like the record to show just a little more fully just what the State and Territorial Health Officers' Association is. As I understand, it represents the 48 States, the Territories, and the District of Columbia.

Dr. GETTING. That is correct, sir.

Senator DONNELL. And what are those health officers, generally speaking, the heads of the departments of health of each of those States and Territories? And the District?

Dr. GETTING. That is correct, sir.

Senator DONNELL. For instance, in the District of Columbia, who is this health officer?

Dr. GETTING. Dr. Reilly.

Senator DONNELL.. What is that?

Dr. GETTING. He is, I believe, the health officer of the city of Washington.

Senator DONNELL. Now, in the usual State, take for instance some particular ones, Pennsylvania and New Jersey, what are those health officers called?

Dr. GETTING. Sometimes commissioner of health; sometimes secretary of the board of health.

Senator DONNELL. In other words, they are officers that have general supervision over the betterment of the health of people throughout the boundaries of their entire States?

Dr. GETTING. That is entirely correct, Senator.

Senator DONNELL. We ought to mention that because as the head of that organization you would undoubtedly have an organization behind you that represents various sources of information?

Dr. GETTING. Yes; and while we have only 25 members we have a great many technical subcommittees, which consist of the staff of these various State health departments, who assist in formulating our technique and administrative policies.

Senator DONNELL. Does the association have periodic meetings?

Dr. GETTING. Yes, sir; we have annual meetings, usually held in December, and we have several meetings throughout the year, and the executive committee may meet as often as necessary, either here in Washington or anywhere else.

Senator DONNELL. How large a committee is the executive committee?

Dr. GETTING. It consists of six.

Senator DONNELL. How large a gathering did you have at the last meeting?

Dr. GETTING. All the State officers, with two or three exceptions, or their representatives were there.

Senator DONNELL. Was the subject of compulsory health insurance discussed at that meeting?

Dr. GETTING. Practically all pending legislation is discussed, and the compulsory health was discussed.

Senator DONNELL. Yes, sir; and were any resolutions adopted by the meeting of December 1946 on the subject of compulsory health insurance?

Dr. GETTING. No, sir; we adopted no resolutions.

Senator DONNELL. Doctor, I notice with much interest this language on page 12 of your statement:

> It is necessary that the States be furnished as complete freedom as possible for the administration of a health program so as to best meet the needs of their individual populations. The State and Territorial Health Officers, therefore, approve wholeheartedly the principle of States' rights as exemplified in this bill.

You are referring to S. 545, are you not?

Dr. GETTING. Definitely.

Senator DONNELL. Has your executive committee discussed that phase of the bill in detail?

Dr. GETTING. Oh, yes. This statement, I might state, was written jointly by Dr. Beelman, our president, and myself after communicating with all the State health officers either by telephone, word of mouth, or by communications, letters.

Senator DONNELL. How wide an experience in medical matters have you personally had, doctor?

Dr. GETTING. I have been a city health officer.

Senator DONNELL. In what city?

Dr. GETTING. In the city of Worcester, with a population of 200,000. I have come up from the lowest rank in the State health department to my present position as State health officer. I have been licensed to practice medicine since 1935. I am a graduate of not only medical school but I am a doctor of public health as well. I am a member of the committee on medical economics of the Massachusetts State Medical Society, the American Public Health Association, and I have sat with many groups discussing Federal legislation on whose committee I am dealing with Federal legislation as well.

Senator DONNELL. Now, doctor, you were kind enough to testify before the predecessor committee to this one last year on S. 1606.

Dr. GETTING. Yes, sir.

Senator DONNELL. Have you examined S. 1320, the bill which was recently introduced by Senator Murray and others?

Dr. GETTING. I have. Like the gentleman from Montana, I have read the bill several times and certain parts numerous times; but I have not as yet prepared any statement should a hearing be held.

Senator DONNELL. I shall not go into detail on that as to the bill, but I would like to find out something as to the matter of the cost of that bill. I understand you are not here prepared this morning, doubtless, in the detail, but we had some very helpful figures from you last year in 1946, April, with respect to S. 1606.

Dr. GETTING. In the first place——

Senator DONNELL. At that time I understood that you testified in substance that you believed that the sudden overwhelming expansion as envisioned in S. 1606 of a multiple medical-care program administered by numerous agencies on both Federal and State levels would not only prove too costly but be confusing to the public, is that correct?

Dr. GETTING. That is correct.

Senator DONNELL. I am quoting from the question asked you at page 844 to which you responded, "Yes."

Now, on the matter of the cost of an insurance program such as envisioned by S. 1320, I am wondering if you would object if I read just a little of your testimony relating to S. 1606, and see how it compares with or differs from your testimony on S. 1320 as affects cost.

I quote again from your testimony on page 844 of the hearings in 1946. You say:

> The experience, I believe, on the west coast, has demonstrated that the average cost per capita of a complete medical-care program is approximately $34. That was several years ago. Surveys conducted by dental societies have indicated that the average need for dental care is $30 per capita for an adult.

I pause at that point. You mentioned, I believe, this morning that every child should have some dental care every year.

Dr. GETTING. That is correct.

Senator DONNELL. And that is doubtless true of adults as well as children, is it not?

Your answer was in the affirmative?

Dr. GETTING. Yes, sir.

Senator DONNELL. I proceed with this testimony of 1946 from yourself. You stated this:

> I think that under an insurance program which brings about an additional stimulation and inducement to people to obtain additional medical care, this cost would be substantially increased. So I think that the lowest figure you could assume would be $70 per capita, and a more accurate figure might be, perhaps, $100.

Dr. GETTING. That is my opinion.

Senator DONNELL. Then this question:

> As I recall the testimony, this bill, as it is now drawn, would probably apply, I think, Mr. Chairman, to from 105,000,000 to 112,000,000 of our population. Am I correct in my recollection?
>
> The CHAIRMAN. I believe those are the figures.

Senator **Donnell**. If it were 105,000,000 people. Doctor, and the per capita cost of it were $70, the lower of the two figures which you mentioned, that would be, as I figure it, $7,350,000,000 a year.

Dr. **Getting**. Approximately.

Senator **Donnell**. And if it were $100 per capita, it would be $10,000,000,000 per year. That is correct, is it not?

Dr. **Getting**. I believe this is correct. I get confused with so many zeros.

* * *

Senator **Donnell**. I do, too. Let us see. Start out here with 105,000,000 people and we add two ciphers on here for $100 a person, would we not?

Dr. **Getting**. That is right.

Senator **Donnell**. Then punctuating off like this, we would get $10,000,000,000. I think I lopped off five hundred millions inadvertently.

Dr. **Getting**. That is right.

Then the question:

So, your estimate, as I understand it, which I take it is merely an estimate for the cost of title II, prepared personal health service benefits, if applicable to 105,000,000 people, would be from $7,350,000,000 per year to $10,500,000,000 per year?

Dr. **Getting**. That is my estimate.

Senator **Donnell**. If it were applicable to 112,000,000 people instead of 105,000,000 people, it would be 112/105 of those respective figures?

Dr. **Getting**. Yes. If you have the medical care of the needy included, your total expenditure covering approximately 90 percent of the population would be correspondingly increased, so that you might have, let us say, 130,000,000 times $100, which would give you $13,000,000,000, I believe.

That was the testimony back there in April 1946.

I will ask you to state without getting down to the detail of it, unless you desire to, whether or not your observations there as to the cost under S. 1606 would be, in your opinion, substantially the same figures as would apply to S. 1320? That is the bill now before you.

Dr. **Getting**. I believe that without going into any details any changes that there might be—if, assuming that S. 1320 covering the same group of the population as the old Wagner-Murray-Dingell bill covered, that we have no reason to revise our figures in any way except, perhaps, to adjust them for the increased costs of hospital service and increased fees charged for medical and dental services.

Senator **Donnell**. In other words, assuming that the bill does have the same coverage as does S. 1606, it would probably be more than the figures you mentioned in April 1946?

Dr. **Getting**. I believe that would be a justifiable conclusion or deduction.

Senator **Donnell**. I may say I am not making representations to you as to comparative coverage. We have not explored S. 1320 in great detail yet, but I take it, regardless of whether there is the same coverage or not, if there is a proportionate increase or decrease in coverage, the figures would correspondingly increase or decrease as to cost.

Dr. **Getting**. That is correct.

I might add, Senator Donnell, that one thing we like or prefer about S. 545 is that it does not suddenly plunge us into an over-all program. It begins a program with a small segment of the population and one for which we could reasonably prepare. It is a single medical-care program which, if amended as we suggest, would be much more feasible of practical administration than the confusing polyglot program that was prepared in last year's Wagner-Murray-Dingell bill.

Senator DONNELL. Doctor, in your testimony of last year, you discussed briefly, right at the outset of your testimony, S. 1318, which was the Maternal and Child Welfare Act.

Dr. GETTING. Yes, sir.

Senator DONNELL. And you said this, referring to the basic principles, you state

> It is convinced—

that is, your association—

> that certain basic principles must be adhered to if a medical-care program is to be successful.

As they apply to S. 1318, if I might say to the amendments proposed by Senator Pepper and Wagner-Murray-Dingell, these principles are as follows. There are two of them that I will not mention here but the third one reads as follows:

> Medical care should be extended as needed but should be limited to individuals unable to provide such care for themselves.

Now, is that your thought today and does that view prevail with respect to the coverage that would be envisioned by S. 545, in your judgment?

Dr. GETTING. That is essentially correct. I would like to modify it in this way, however. It is possible that some of the States, after seeking advice from the public and the profession rendering the services, might wish to broaden the scope of a medical-care program at some future date.

It would be impossible to make a single medical-care program in conjunction with this S. 545 because this limits it to the low-income groups and it would be a lot better if it were left to the judgment of the State after advice from the professions and the public as to what segment of the population it should apply to.

By that I mean in some States they might want to take as low income one of about $1,000. In another State it might be $2,000; in another State it might be three or four thousand; and it varies, and I believe we should not have to resort to low—or an artificial definition of low income.

So we suggested for that reason that instead of limiting this to low incomes that the States be given the discretion that they might determine what segments of the population will be covered.

As to collection of fees, we felt again that the State should determine what machinery it can develop, whether it should collect part payment or no payment.

In certain types of illnesses, for example, like giving care for teeth, for example, an ordinary prophylaxis or the filling of dental cavities in a school child, the cost of making a real investigation to determine the need or ability of that child to pay would cost more than the filling of the cavity would. In that instance, we would suggest that after study and consultation with all parties concerned, that no attempt be made to collect fees.

On the other hand, a major illness—it might be possible to develop a method without resorting to means test where the physician would determine in his judgment that this patient can afford to pay part or pay the whole cost.

And upon that determination the State could then exercise its authority to pay part or whole.

But that should be left to the discretion of the State, and it should be determined only after advice of the professional societies and the public.

I do not think that we should say that you have got to do this; let the State decide what are the best to meet its own needs.

Senator DONNELL. That recognizes the principle and the fact, does it not, Doctor, that there may be varying conditions in different States. One State might find one course of procedure advisable and another may not.

Dr. GETTING. That is entirely correct.

Senator DONNELL. Which tends to emphasize the advisability of leaving as much as possible to the States to determine matters of that kind rather than to leave it to the Federal Government as an over-all proposition to lay down the rules to all States.

Dr. GETTING. You notice all we did in suggesting a change is to make it permissive rather than mandatory.

Senator SMITH. Doctor, following that same line of thinking, would you think that as we progress in our experience, we learn from the State agency something we did not know and we can take it up from there? In other words, accumulate experience in the development of an over-all sound program rather than try to write a blueprint at the beginning to cover the whole picture?

Dr. GETTING. That is one of the purposes of our organization, to exchange information from one State to another.

That is why we hold periodic meetings to learn what our neighbors in other States are doing and to benefit from their experience.

Senator SMITH. You feel S. 545 would be in line with your whole philosophy of interstate organization and development, if necessary, and the sound development of a program to take care of these health programs.

Dr. GETTING. If we could get these two changes: Inserting the word "may" where it reads "shall" and giving authority to States after advising with the professions and to determine what segment of the population would be eligible; that would lay the groundwork upon which all our public-health and medical-care programs, if any, can be laid.

In other words, this would be the foundation. If we find that we need to expand, we can expand; if we find that we do not need to expand, we do not have to expand. But it would be done only after advice of the professions and of the public and after making an adequate over-all survey.

Senator SMITH. Some of the records or reports I have read, have indicated that there are some States that are backward in the development of their public-health services.

Now, does your organization contribute anything to helping those that are backward with ideas and advice and so forth? Is that part of your plan or do you simply exchange views and so on?

Dr. GETTING. If we have 48 people in a room, there will be some differences. Some of us would be better than others and some of us would be worse than the other fellows. The same with 48 States. Some have leadership in one field, some in another.

For instance, in Massachusetts, we have the only State that is distributing blood plasma and whole blood free of charge and we are having people from other States and all over the world, as a matter of fact, coming into the laboratory and studying.

Similarly, we send people to other States and study their methods and in that way we exchange information and ideas. We are constantly trying to improve ourselves and others.

Senator SMITH. So that it is a contribution to the whole picture.

Senator DONNELL. Improves the general picture.

Do you have before you S. 545?

Dr. GETTING. Yes, sir.

Senator DONNELL. Would you be kind enough to turn to page 17? That is section 712, subsection (a) and subdivision (1) thereunder. It is provided in substance by the portion of section 712 to which I have called your attention that any States desired to take advantage of that title may submit a State plan for carrying out its purposes—that title reading "Medical Care Services." And it further provides that such plan must designate a single State agency as the sole agency for the administration of the plan or designate such agency as the sole agency for supervising the administration of the plan. It says, "Providing"—and this is the proviso to which I especially direct your attention:

> Providing that on or before 1949 such agency shall be the State health agency.

Would you be kind enough to advise us, Doctor, and state your reasons for your opinion, please, as to whether you think it is a wise provision to have the State health officers administer the State plans.

Dr. GETTING. I think it is not only desirable but almost obligatory that they should.

In my testimony—the reason we did not cover it in this statement is that we have already gone on record stating why we think it is desirable or preferable. The State health departments are now administering certain medical-care programs. Some of us operate hospitals and out-patient departments and rapid-treatment centers and things of that nature.

We have some supervision of the school-health program. We administer the tuberculosis-control programs, venereal-disease-control programs, cancer, chronic diseases, and the like, and it would be foolhardy to assume that there should be either a duplication of administrative machinery in a State or that we should set up another agency to deal in the same field.

We have observed that in some welfare departments, medical-care programs for the indigent have been administered.

I might say that in some places it is done well but that in a majority of the places it is my opinion, and only my opinion, that it could be vastly improved.

We know of some city physicians employed by welfare agencies where the city physician collects as little as 16 cents per visit.

Now, you and I know that no physician can do a thorough job if that is all he gets for visiting a patient, and the quality of medical service is extremely poor.

We also are convinced that in order to keep the quality of medical care high, and that is absolutely necessary—it is not quantity that counts; it is quality—that medical administration which has complete understanding of the problems of clinical medicine is absolutely necessary to the successful operation of a program and the State health officers with their staff, with their administration of the crippled children's services, the emergency maternity-infant care program, have had ample experience to take on this new responsibility and are best qualified to do so.

Senator DONNELL. Thank you, Dr. Getting.

Senator Smith, have you other questions?

Senator SMITH. No further questions.

Senator DONNELL. Again I emphasize our appreciation of your coming with this very fine contribution to the data at hand.

Dr. GETTING. Thank you kindly for the opportunity.

Senator SMITH. May I make this statement before you call the next witness?

I want to express my appreciation of Senator Donnell's taking the chairmanship today. I was prevented from being here earlier by another matter of great importance, another committee on which I am serving.

I just want to say for the record, and possibly Senator Donnell said this already, that yesterday I received a communication from Senator Murray expressing his regret that he could not be here today, expressing particular regret that he could not be here to hear Dr. Shields, of Montana, and he asked whether we could possibly have this hearing this afternoon when he could be here. I explored the matter and I found that our whole committee is meeting this afternoon to consider some pending bills and I also discovered that Dr. Shields was unable to stay over until tomorrow, so it was necessary to hear him this morning even though Senator Murray was not present and I am certain you will recall I asked you to say that Senator Murray expressed great regret to Dr. Shields that he could not be here when he testified.

I just want that for the record, to indicate regret by Senator Murray at his inability to be here this morning.

Senator DONNELL. I appreciate, Senator Smith, your supplementing the statement I made with respect to that matter.

Mr. Fichter.

(Dr. Getting submitted the following brief:)

STATEMENT FROM THE STATE AND TERRITORIAL HEALTH OFFICERS' ASSOCIATION ON S. 545, NATIONAL HEALTH ACT OF 1947

(Submitted by Dr. F. C. Beelman, president; Dr. V. A. Getting, secretary-treasurer)

The State health officers have always been concerned about legislation relating to the health of the people of this Nation. We appreciate this opportunity to express our views on so important a subject as the National Health Act of 1947, S. 545. We appear before you representing the State and Territorial Health Officers' Association. Membership is limited entirely to the health officers in direct supervision of the health programs of the States or Territories of the United States. At the present time, there are 52 members representing all of the States and Territories. Without one exception, all are doctors of medicine and are members of their respective professional organizations. The primary purpose of the association is to express, through their officers, the views of this select group on various matters pertaining to health. In some States these health administrators are appointed directly by the Governor as health commissioners—in other States they are appointed by State boards of health and serve as the executive officer and secretary of the board. The health programs they administer vary greatly. Some State health agencies have several thousand employees, expend millions of dollars in State funds, and administer both preventive and curative medical programs. Others are small and limited in both personnel and funds; however, all carry on, to some extent, the same types of activities and have somewhat similar responsibilities and organizational patterns. For example, the majority of State health agencies have had years of experience in the control of communicable diseases, environmental sanitation, food sanitation, registration and interpretation of vital statistics, laboratory services, maternal and child-health programs, intensive programs in the control of the venereal diseases and tuberculosis, together with broad health educational and promotional programs. In recent years, programs have been started in industrial hygiene, cancer control, dental hygiene, mental health and, of late, survey and construction of hospital facilities.

The majority of State and local health departments or agencies were started less than 75 years ago. A careful analysis of the factors active in the increasing length of life of the American people, will reveal that the health programs started and carried on through the years by State and local health agencies were dominant in increasing the expectancy for life. In that time the 10 leading causes of death, which encompass from 75 to 80 percent of all deaths, have changed greatly. Germ-borne diseases, which were the leading causes of death in the United States 50 years ago and were considered an inseparable part of our environment, have been greatly reduced and, in the course of time, may be completely eradicated. A typical example is the reduction of tuberculosis. Today we can look with confidence into the future and know that this great scourge of mankind can be eradicated. Reduction in deaths from germ-borne diseases has projected into prominence other disease conditions. Heart disease, cancer, diseases of the vascular system, and nephritis, the first four leading causes of death today, can only be reduced through early detection of normal to pathological tissue changes. This means that our health programs must start with the apparently normal, well individual. Greater emphasis must be placed upon diagnosis; improved diagnostic techniques, equipment, and facilities must be provided. The conditoning of well persons, to take advantage of all modern scientific medicine, is a long-range, educational job. Once pathology has been established in normal tissues, and has run its usual course in these four leading causes of death, provision of all the medical care in the world will not save from death this large group of our population. Compulsory, national medical-care programs are not the answer. In our opinion, death from these diseases knocks just as often at the door of the rich as at the poor. Dr. Louis Dublin, statistician of the Metropolitan Life Insurance Co., in a recent study of deaths of physicians, finds that they vary directly as the general population death rates of given areas. For example, the general population death rates are lowest in the area comprised of Kansas, Nebraska, South Dakota, North Dakota, Minnesota, and Missouri, which has also the lowest death rate among physicians. The Southeastern States have the highest general population death rate, and there also is found the highest death rate of physicians. In heart disease—the leading cause of death—the death rate among physicians is greater than in the general population. The physician, of all of our people, does have available the best possible medical care. He has easy access to diagnostic and hospital facilities. Yet, the death rate of the physician varies directly as the death rate of the people in the area in which he lives.

Accidents, the fifth cause of death, should not be overlooked. Many are preventable and thought must be given to programs aimed at their reduction. Persons affected with diabetes, tuberculosis, prematurity of infants, degenerative tissue changes of the aged, the leading causes of death, need more than medical care; they can be saved only through early diagnosis and prevention. Likewise, the leading causes of illness today, starting with the common cold and upper respiratory diseases—measles, mumps, mental diseases, and others—need, as yet, a great deal of research.

We assume that behind any national health act is the desire of the authors to reduce, insofar as possible, the preventable deaths, illnesses, and suffering of our population, as well as to promote and maintain optimum health. S. 545 is the first congressional medical care bill proposed, in our opinion, that so far lends itself to those objectives after amended. However, the State health officers feel that any legislation that will substitute an unknown, nationally controlled system of compulsory medical care for any segment of our population to the present pattern of medical service, may jeopardize the well-being of the American people unless it is well integrated with existing facilities. Our present system is wholly democratic in its organization and service. The general health of our people, in terms of mortality and morbidity rates, improved during the war, in spite of the shortage of physicians and hospital beds. The natural growth of medical knowledge and evolution of the medical profession in its inherent, continuous struggle to improve its techniques and individual skills, promises even greater benefits to humanity. The commitment of the American Medical Association, which represents the majority of medical physicians, to the broad health program, as outlined in 10 major items, should be considered by this committee. The principles advocated, could serve well as a guide in the preparation of Federal legislation aimed at improving the health of the Nation.

Let us not be hasty in dealing with the lives and health of our people. Medical care surveys and studies as recommended in S. 545 are necessary if we are to intelligently deal with this complex problem. Surveys, studies, and interpretation of the material accumulated and the preparing of a sound health program can only be done with the assistance of trained physicians having complete knowledge and experience with the factors influencing life and health and with the wholehearted cooperation of the geenral practitioners found in every community, and upon whose shoulders the entire program must finally rest.

DISCUSSION IN DETAIL S. 545

Title I. Organization: In our testimony presented on hearings on S. 140 and S. 712, held before the Senate Committee on Expenditures, we indicated that the State and Territorial Health Officers were in favor of the organization of, first, a National Department of Health under the direction of a Cabinet member or Secretary, who would presumably be a physician trained and experienced in the administrative aspects of public health and medical services. We also indicated that we feel, under the present structure of the Federal Government, there was little chance of the creation of a separate department of health and we, therefore, as a second choice, suported the creation of a combined Department of Health. Education and Security, and presented an amended bill for S. 712 which would, in effect, create such a department by the conversion of the Federal Security Agency into a new Department of Health, Education and Security.

The State and Territorial Health Officers are not convinced that the creation of a National Health Agency, as proposed in this bill, is conducive to the most efficient and economical administration of a national health program.

In analyzing this bill, the association concluded that the organization of the National Health Agency, as set forth, has several shortcomings which may be summarized as follows:

(*a*) The National Health Agency, as proposed, is not a department with a Cabinet Secretary at its head.

(*b*) The Administrator of the National Health Agency is required to be a physician licensed to practice medicine in one or more States. It is our conviction that if there is to be a physician at the head of such an agency, he should have had at least a minimum of 5 years of full-time health and medical administrative experience. We have seen numerous examples where excellent clinicians or teachers in medical school have made extremely poor medical administrators.

(*c*) The bill provides that the Director of the Medical and Hospital Care Service shall be a doctor of medicine, licensed to practice medicine in one or more States, who has had at least 5 years of active medical practice and who is outstanding in the field of medicine. Here, again, we have the same criticism. A Director should be a physician who is not only licensed to practice medicine, but who has had at least 5 years of full-time health and medical administrative experience of a responsibility and size, which would warrant his competence to the position of Director of such an important organization. A clinician or outstanding physicial of 5 years' practice in any of the specialties of medicine would not, in our opinion, be acceptable qualifications for this position.

(*d*) The United States Public Health Service is an old, well-established governmental agency. It has been cooperating with State departments for more than half a century. At present, it is the strongest, most acceptable agency at the national level administering Federal health programs. Through the years, its general policies have been to promote State and community responsibility for all health programs. Unlike many other activities carried on by Federal agencies, with offices in each State—public health, today, following that long period of cooperation, is entirely in the hands of State and local administrative officials. There has been much confusion on this point, and it is misunderstood by both professional and political groups. When a State elects to accept grants-in-aid funds for a given health activity, both the funds and the responsibility for the program are in the hands of State and local health officials, as long as certain rules and regulations are followed. With all its faults, the United States Public Health Service is in a position to be reorganized, strengthened, and made the nucleus of a health agency, able to resist the many and varied pressures from all sources, as they may develop to weaken the effectiveness of national health programs.

We recommend that, in the creation of a National Health Agency, if one is to be created, serious thought and consideration be given to its development about an existing organizational set-up, which has already proved itself to be experienced, efficient, and economical in the administration of public health. This organization is the United States Public Health Service, and the formation of the new agency can be developed about this organization.

It is further suggested that efforts should be directed toward making this agency a department, with a Cabinet health officer at its head, who shall have the usual authority and powers of any Cabinet officer in the administration of his own department. The specification that the agency should have various constituent units; namely, the Office of Administration, Office of Public Health, Office of Medical and Hospital Care Services, Office of Dental Care Service, etc., makes it incumbent upon the Administrator to form such units, without giving him an opportunity to study the organization of the department, and form such units as his study and investigation will reveal to be best suited for the efficient administration of the national health program. Moreover, the authority vested in the proposed Administrator of this National Health Agency is vague and uncertain. To him is transferred some of the authority now vested in the United States Public Health Service and the Surgeon General. Likewise, to him are turned over some of the responsibilities now vested in the Administrator of the Federal Security Agency. However, the responsibilities more recently given the Federal Security Administrator in the President's Reorganization Plan No. 2, and with the passage of Public Law 725, are not assigned to anyone in the new Health Agency, but would remain apparently with the Administrator of the Federal Security Agency. It is necessary, therefore, to review carefully not only the organization of the National Health Agency, but to carefully integrate the United States Public Health Service and use this as the nucleus in the formation of such an agency, and to review carefully the authority and responsibilities assigned to the Administrator of such an agency. If the Federal Department of Health, Education and Security is formed, it is still the recommendation of the State and Territorial Health Officers that the Surgeon General be the head of the Health Division and that the administration of medical-care programs be carefully integrated under his direction. In our considered judgment the provisions of title I, section 102, on pages 3 through 6, are not so designed as to take advantage of existing facilities already efficiently operating. Thus, the simplified and economical administration of health programs, which the United States Public Health Service, in cooperation with State health agencies, has so ably carried on would be lost. Instead, there would be a cumbersome and unwieldy, costly superstructure imposed upon the existing organization, with some substantial duplication of administrative facilities, without proper control of these various divisions by the Administrator of the agency.

It is therefore, our recommendation that the Administrator of the Agency be given authority to reorganize such divisions and bureaus in the department as, after study and investigation of a year or more, he finds best suited to meet the needs of the Nation. Sections 103 and 104. on pages 6 through 10, should, therefore, be revised to permit such discretion on the part of the Administrator. The State and Territorial Health Officers are in sympathy with section 108, on pages 11 through 12, calling for a study to be made of the Commission Corps of the United States Public Health Service. We feel, however, that no time limit should be put upon such a study and that the study should be designed toward the end that more effective means would be developed for attracting qualified, trained, and experienced personnel of all professional categories to the United States Public Health Service. The present shortage of public health personnel is all but catastrophic, not only in the State health departments, but it is also seriously affecting the United States Public Health Service. Serious thought and consideration must be given to protect the public health of the Nation, by making positions in State and Federal health departments more attractive to qualified personnel.

Title II. Amendments to Public Health Service Act: The old adages, "a stitch in time saves nine" and "an ounce of prevention is worth a pound of cure," are apt in opening discussion of title II of the National Health Act of 1947. The State and Territorial Health Officers are convinced that the Government must provide total coverage to the Nation with adequately staffed, full-time local health departments, in order to assure the availability to all of the people of the Nation the benefits of preventive medicine before we attempt to administer Government medical care programs of any kind in these same areas. At the present time, approximately 40,000,000 people are living in areas without the benefit of services rendered by local health departments. It is imperative, therefore, that amendments to the Public Health Service Act provide increased funds to be used for general health purposes. Such funds as grants-in-aid to States should be sufficiently large to enable the States to subsidize local units of Government on a matching basis, so that all of the people would receive the benefits of public health. To these services, we might add the administration of medical care programs. It is our conviction that such services as maternal and child health, school health services, the control of communicable diseases, special provision for tuberculosis, venereal diseases, cancer and chronic diseases, laboratory diagnosis, nutrition, health education, vital statistics, medical social work, and other accepted functions of public health agencies are a means of preserving the health of the Nation. Without these services, we cannot efficiently or economically administer a medical care program. Our primary objective should be the maintenance of good health and the prevention of illness. After all preventive measures, which are possible in the light of present knowledge, have been applied, there will be an inevitable residual of sickness. It is for the provision of medical and hospital care of these ill persons that a medical care program is needed. Certainly, it would be foolhardy to embark upon a medical care program, without making every effort to reduce illness to an absolute minimum. It is, therefore, the recommendation of the State and Territorial Health Officers that section 314 (c) of Public Law 410 of the Seventy-eighth Congress be amended so as to make available to the States and Territories, additional sums for the provision of local health services to all people.

Our association endorses the cancer program as outlined in section 203 by making Federal grants-in-aid available to the States for this purpose. Since cancer is the second leading cause of death in our population, the ceiling on the amount of Federal funds should be raised so as to enable the several States to carry on adequate cancer control programs, including diagnosis and treatment. The provision of only $10,000,000 for its control is entirely inadequate for the size of the problem.

Title VII. General medical service for families and individuals with low income: The association approves in part the survey of facilities, the determination of need, and the formation of plans to meet such needs as proposed in part A, entitled "Medical care survey." This part is modeled after a similar part of the Hospital Survey and Construction Act, Public Law 725 of the Seventy-ninth Congress. This survey should, of course, be integrated with that required by the Hospital and Health Center Construction Act, and should include public health as well as medical-care facilities. If $3,000,000 are required to make a survey of hospital facilities. there is some question in our minds as to why a similar amount of $3,000,000, as provided in part A, is sufficient to carry on such a survey over a period of years. It is, therefore, our recommendation that the sum of $3,000,000 either be increased or that section 701 be so amended as to make possible further appropriations at a later date.

Part B. The State and Territorial Health Officers are concerned with part B, Medical care service, in that this section limits the scope of the medical care program in a very serious way. The State and Territorial Health Officers are convinced that, if the Government is to sponsor a medical-care program, such a program shall be designed as flexible as possible to permit States to adopt the program to their needs. Because of the limitation of the program to "families and individuals with low income," it would be impossible for any State to expand this program to include other segments of the population should it desire to do so. A single medical-care program would not only be more efficient and economical but would be more receptive to the general public and be of infinitely greater service to it. The definition of low income apparently is to be decided by the various States. If data of the United States Department of Labor is to be accepted, in 1941, 65 percent of all families and single consumers had total annual incomes below $2,000; 85 percent had incomes below $3,000; and 95 percent, incomes below

$5,000. Certainly there is a decided difference of opinion among all authorities, economists, medical, public health and others, as to what might be defined as a low income. Studies conducted by the committee on the cost of medical care in 1928 to 1931, and of the United States Department of Agriculture, have revealed that the lack of provision of medical care is not limited in any way to the lowest income group. For these reasons the Association of State and Territorial Health Officers reaffirms its suggestion that States be permitted, after study and investigation, to fit this medical care program to the segments of population as may, in their opinion, be in need of such services. It is our conviction that separation of the medical-care program for those who are indigent and those who are not indigent may lead to a differentiation in quality of services rendered. The use of the term "low income" also presents the aspect of charity and the means test. Americans believe in the dignity and self-respect of the individual and the integrity of the family. We have our pride and are anxious to maintain our self-respect. We are reluctant to receive the alms of charity or welfare and are anxious to avoid so-called financial investigations to determine our eligibility for charity purposes. For these reasons we feel that the State, rather than the Federal Government, should determine whether or not a medical care program should be made available to all of the people or a certain portion of them. The State, after conferring with the public and with the professions rendering services, can establish a program which might, after a period of experience, be changed from time to time to meet the requirements of the population.

Moreover, the provision of $200,000,000 a year, to be matched by the States on an average of a dollar-for-dollar basis, making a total sum of $400,000,000 available for the provision of medical care, is inadequate to meet the size of the problem. It would be foolhardy to expect $400,000,000 to even scratch the surface, since approximaely 4 to 5 billion dollars are now being expended by all agencies combined for the provision of medical care. Thus, only approximately 8 to 10 percent of the population could be afforded medical care by the use of $400,000,000. Obviously, if this is to be a national health program, the limitation of the appropriation to $200,000,000 a year is inconsisent. The association, therefore, recommends that, after the first year, legislation authorizes such sums as may be necessary, and States wishing to do so, could use these Federal funds for the establishment of well-integrated, comprehensive programs, without resorting to definitions of low income which might be subject to Supreme Court review; that States be permitted to provide for such widespread medical care programs as care of the chronically ill, the improvement of diagnostic and therapeutic facilities designed for all types of illness, in general, special or chronic disease hospitals, in convalescent nursing homes or in custodial institutions.

The State and Territorial Health Officers are somewhat concerned about the dollar-for-dollar matching requirement imposed upon all of the States in an equal ratio. While many wealthy States would thus receive a greater proportion of return from the Federal Government, we acknowledge that there are parts of the country which could not adequately meet such a matching formula. We believe that a variable matching ratio might well be utilized in this program, provided that this variable ratio is based upon a sound administrative formula. The States realize that, because of the more rapid means of transportation and because of the increasing exchange of populations between the States, the health of any one State is affected by the health of all the individual States and, for these reasons, the health officers of the more prosperous States feel that the Federal Government should make due allowance for those States which have a less favorable economic status.

Section 715 provides for the organization of a National Medical Care Council. It is the opinion of the State and Territorial Health Officers that the establishment of a National Health Council would be highly desirable, that such a Council should advise the National Health Agency in its total program, and that such a Council should have only a general advisory function. It is the recommendation of the association that, instead of a National Medical Care Council, a National Health Council be established in which would be combined functions of the various councils outlined in this bill. It would be desirable to increase membership of this National Health Council to include representatives of the various professional groups interested. It would likewise be desirable to give the public a greater voice in the National Health Council than is contained in the National Medical Care Council as defined by section 715. The Council should be given the right and the facilities to make public their recommendations. Such a Council should have strictly advisory functions and not be given administrative or executive authority. The Council might well have committees devoted to special fields. Membership on such committees would not necessarily have to be limited to members of the Council. The administration of the funds of the program, as delegated by Congress, should be the responsibility of the proposed health administrator and his staff.

A review of the provisions of title VII, section 711, indicates that there is no provision for supplementary laboratory, diagnostic or nursing services, or the prescribed medicines and appliances which are necessary if an adequate medical care program of high quality is to be rendered. States are authorized to make agreements for buying services from voluntary medical programs. Such medical care would be limited in many States, since most States' voluntary medical care programs are limited to hospitalization and medical and surgical care in the hospitals. In these States provision should be made for home and office care. Section 712 (4) (b), line 24 on page 18 through line 2 on page 19, reads as follows: "Such program shall provide for the collection of proper charges of less than the total cost of such services from persons unable to pay in whole, but able to pay in part therefor." This imposes an extremely costly administrative machinery upon the State agency. We have determined, for example, that in the rendering of dental care to school children, the investigation by the medical social worker, in order to determine ability to pay, would impose a greater cost for each person served than the services rendered. In Massachusetts, in regard to the distribution of plasma and whole blood and other fractions of blood, we determined that, in order to collect approximately $15,000 from those who could afford to pay in whole or in part for these products, we would have to spend a sum of $10,000 to set up the necessary administrative machinery. In addition to this costly machinery, there would be placed a certain stigma upon those who had services on a charitable basis. The State and Territorial Health Officers do not approve the requirement either in this medical service program or subsequently in the dental service program as required on page 31, section 812 (4), lines 22–25 and page 32, line 1. We do not believe that collection of relatively small amounts of money would, in any way, justify the additional administrative cost. In addition, many who should receive medical care or dental care under this program would be reluctant to seek it for fear they might be labeled as recipients of charity. The State and Territorial Health Officers, therefore, recommend the deletion of the word, "shall," in line 24 on page 18 and substitute therein the word, "may." We also recommend the provision of supplementary laboratory and diagnostic services, bedside and public health nursing, and the supplying of drugs and appliances when necessary.

Title VIII. Dental health services for school children and families and individuals with low income. The Association of State and Territorial Health Officers endorses, in principle, the dental health services for school children and for the segment of population as might in the judgment of the State be entitled to such services.

Part A. A dental survey should, in our opinion, be integrated with the original survey as provided by title VII, part A. An over-all survey of public health and medical care facilities should include all of the facilities in a State intended to maintain or improve the health and take care of the sick. Therefore, it is our suggestion that section 801 be integrated with section 701.

Part B. Dental care services: All school children need some dental care each year. Although the annual inspection may screen out those who need more extensive remedial or corrective services and, in addition, may focus the spotlight of public attention on the great amount of dental caries which might be prevented, such routine examinations should not be required annually. Certainly, the reports on physical examination of men under selective service indicates, to some extent, the need for broad, dental health services for children. The State should be permitted to determine, in its judgment, after proper advice of the public and those rendering the services, as to the content and scope of the dental program it wishes to develop. Dental care should be extended to all those who cannot obtain such services.

The State and Territorial Health Officers favor the extension of dental services to all school children, regardless of income and to such segments of the adult population as may be determined in the opinion of the State to be desirable without limitation or prescribing to the content of the program, except for the setting of minimum standards by the national agency. The provision of a National Dental Health Council is again best integrated in the over-all Advisory Health Council previously recommended. A subcommittee might devote its attention to dental health. We do not believe that it is necessary to set up a separate National Dental

Health Council. Moreover, such a National Health Council, as explained before, and its subcommittee, should be purely advisory with no administrative or executive authority.

Title VII and VIII combined: The Association of State and Territorial Health Officers believes that grants-in-aid from the Federal Government to the several States should be channeled through a single office, preferably the United States Public Health Service, and a single plan and budget and report be required for the complete coverage of all.

The setting up of multiple divisions with authority to approve plans is not conducive to consolidation and coordination of Federal and State health programs. We believe that the Federal agency should have authority to set minimum standards in the technical aspects of the program, and to require that all personnel employed meet certain minimum standards as might be set up in State merit systems. We, therefore, recommend that the United States Public Health Service be authorized to set minimum standards as to content of program, and to require that persons employed meet the requirements of State merit systems, and that all regulations pertaining to the administration of these programs be presented to a conference of the State and territorial Health Officers prior to their enforcement, and that advice and approval whenever possible be obtained from the State and Territorial Health Officers in advance. It is necessary that the States be furnished as complete freedom as possible for the administration of a health program so as to best meet the needs of their individual populations. The State and Territorial Health Officers, therefore, approve wholeheartedly the principle of States' rights as exemplified in this bill.

Title IX. Further research and training: The Association of State and Territorial Health Officers approves part A setting up a dental research program in principle but desires to see the ceiling increased for this purpose. We recommend that no legislative ceiling be placed upon the funds for research within the National Institute of Health, and suggest that the bill authorize such appropriations as may be necessary. The Surgeon General is required under section 903 to turn to the National Dental Health Council for advice relative to research projects or programs. It is suggested that a Dental Health Advisory Council be a subcommittee of the National Health Council, as previously developed in our testimony. Thus the advice from the Dental Advisory Council would channel through the parent organization to the Surgeon General.

Title III. As has already been explained in our testimony, all authorities now vested in the Surgeon General and Federal Security Administrator will not be transferred to the new agency proposed by this bill. A careful review should be made of existing laws to make sure that the Administrator of the National Health Agency or the Administrator of any proposed Federal Department of Health Education, and Security, is given the necessary authority to administer the laws, such as Public Law 725, and authority now vested in the Federal Security Administrator under the President's Reorganization Plan No. 2.

No provision is made in this 1947 National Health Act for the training of personnel necessary to meet the expansion of public health and medical care services, envisioned by the act. To meet this need, the State and Territorial Health Officers recommend: (1) Funds to be made available to schools of public health, medical schools, and other professional schools for the training of personnel required for the administering of these programs and for rendering services; (2) funds on a fellowship basis through State health agencies be made available to individuals seeking such training. Such funds should provide for adequate training of physicians, nurses, dentists, and other professional help necessary to implement the administration and rendering of services.

Because of the possibility of epidemics or unpredictable illness, provision must be made in any medical care program for meeting such contingencies or emergencies as may arise through no fault of any agency. It is, therefore, suggested that more adequate provision be made in this bill for assisting States in such outbreaks or emergencies as may occur through an act of God, such as hurricanes, floods, and the like. Certainly, States should not bear the entire burden of such unpredictable emergencies, and it is desirable to make provision in this law for complete coverage under such unusual circumstances. This may require amendment to section 307 on pages 46 and 47.

Summary: The State and Territorial Health Officers support in principle S. 545 and believe it will meet some of the needs of the people for more adequate public health and medical services. We are, however, suggesting certain changes in the administration of the National Health Agency, primarily the preservation of the United States Public Health Service as an efficient nucleus about which to develop the new Agency; the expansion of public health services so as to reduce illness to a minimum at the same time as we attempt to provide medical care. We are in entire accord with the principle of States' rights and the vast amount of authority which is left with the States in the administration of his program. We suggest, however, that this authority be broadened so that States may make a single, conclusive medical care program, if they so desire, after advice from the public and professions rendering medical services. The State and Territorial Health Officers are pleased at the interest the committee has expressed in the expansion of public health services and in the sympathetic understanding that they have evidenced in the past in meeting the problems for health and medical services. We wish to express our gratitude to the committee, for the opportunity to appear before them and represent the State and Territorial Health Officers, who will be charged with the administration of this program on the State level.

STATEMENT OF JOSEPH W. FICHTER, CHAIRMAN, INTERIM HEALTH COMMITTEE, NATIONAL GRANGE, COLUMBUS, OHIO

Senator DONNELL. Will you please state your name and address and tell us something of the Ohio State Grange, in behalf of which, I take it, you are appearing here this morning?

Mr. FICHTER. I should like to say, Mr. Chairman, if it meets with your permission, and the permission of the committee, that I am the master of the Ohio State Grange; my address is Oxford and Columbus, Ohio, and I am chairman of the interim committee on health of the National Grange and it is as chairman of this committee that I should like to speak on the bill.

Senator DONNELL. How large an organization is the Ohio State Grange?

Mr. FICHTER. Approximately 110,000 members.

Senator DONNELL. Are those members entirely farmers or is the membership open to others as well?

Mr. FICHTER. The membership is open to those who are interested in agriculture. Most of them are farmers but there are people who belong who are not farmers.

Senator DONNELL. Has the Ohio State Grange considered from time to time the subject of dealing with health problems and particularly the subject of compulsory health insurance?

Mr. FICHTER. It has considered the health problems. We have not considered the matter of compulsory health insurance as such.

Senator DONNELL. Very well, will you proceed with your testimony?

Mr. FICHTER. I wonder if, before I proceed, it would be agreeable if I could divide my time with Dr. Lloyd Halvorson, who is secretary of the committee on health and economics of the National Grange.

Senator DONNELL. That would be satisfactory; yes, sir.

Mr. FICHTER. The National Grange is a Nation-wide farm organization with 750,000 members. Our members are vitally interested in measures designed to improve the rural health situation. We know, not only from statistics, but from actual contact with the situation that all is not well with rural health. We feel that much can and must be done to improve rural health.

In 1940 the death rates of rural infants, preschool children, and youths 15 years of age and over were higher than those of residents of large cities. The maternal mortality rate in 1941 was almost one-third higher in rural areas than in the big cities. Many of the infectious diseases for which modern medicine has the know-how for conquering are more prevalent in rural areas than in the cities. A larger proportion of rural youth were rejected for military service than city youth.

A study of infant deaths in Ohio showed that in the 5-year period preceding March 1946 more than 25,000 infants under 1 year of age died. In three cities of the State the infant death rate was less than 20 per 1,000 births; but in a number of areas, mostly rural, the rate exceeded 60.

The medical personnel facilities in rural areas are very inadequate. A recent survey in Ohio by the Ohio Medical Association brought to light these facts: Ninety-one towns of 500 population and more have no doctor; 38 towns of 500 population and more need additional medical assistance; 15 towns of 500 population and more need specialists. It was also found in this survey that most doctors do not expect to go into rural areas because of lack of facilities for diagnosis, lack of hospital facilities.

Another survey in Ohio showed that the large metropolitan areas had 76 percent more physicians and 79 percent more dentists in proportion to population than did the rest of the State, which contained most of the rural population. In respect to hospital beds, the disparity was even more accentuated.

Not only in the rural areas of Ohio are medical personnel and facilities inadequate; the same situation exists in most all communities of rural America.

We need to say a few words as to the factors responsible for the low level of rural health in order to be better able to deal with the problem. First, farm people have a lower per capita income than city people. In the 1935–39 period the per capita income of city people was $603, but for farm people the per capita income was only $243. Even in 1945 the per capita income of farm people was only $743, compared with $1,259 for people not on farms.

The low-income level of farm people means that rural areas are often unable to attract and hold doctors and to provide health facilities. In addition, to make the problem worse, many doctors prefer to live in the larger cities. This is to some extent a reflection of the fact that relatively fewer farm people can afford to send their sons or daughters to medical school than city people.

The farm business is of such a nature that farm people cannot live close together—such as in cities. This situation is the source of many health-service problems, as you can well imagine.

Because medical facilities and health services have lagged in rural areas, understanding of what modern medical care can offer is lacking in some farm families. Education must go hand in hand with making medical facilities available.

The nature of the farm business poses some difficult problems in the administration of health programs. Many city people are on a salary or wage basis; therefore, their income can be quite readily ascertained. Workers in an industrial establishment form a natural group health prepayment plan, and pay-roll deduction facilitates collection of premiums or subscription rates. On farms we do not have this situation.

The National Grange views health of the people as a humanitarian matter, and also as a matter of the general welfare. Also, we recognize that with better health more people would be able and willing to take care of themselves and to advance their economic status. With these considerations in mind, the National Grange in November 1946 adopted the following health objectives:

> That rural people share fully in the benefits of modern medical science regardless of economic status, race, or geographical location.

We have a number of points in our health program which are designed to help attain this program. They are as follows:

1. Improved accessibility, availability, and quality of hospital and medical facilites in rural areas.
2. An increased number of well-trained physicians with proper distribution in rural areas.
3. A medical cost payment system which will enable all people to secure modern medical care without undue burden.
4. A rural citizenry informed as to what constitutes adequate medical care and its importance, and a citizenry informed as to how it can best be secured for all.
5. Adequate public health services.
6. Increased research in the various fields of health.

We are attaching to this statement the complete health program of the National Grange. I should like to ask also if I may have the privilege of attaching to this a copy of the address by Mr. Albert Goss, master of the National Grange which he made before the national conference on rural health at the Palmer House, Chicago, on February 7, 1947.

Senator DONNELL. It will be received for the record.

Mr. FICHTER. Thank you.

(The address referred to is as follows:)

ADDRESS BY ALBERT S. GOSS, MASTER OF THE NATIONAL GRANGE, BEFORE THE NATIONAL CONFERENCE ON RURAL HEALTH, PALMER HOUSE, CHICAGO, ILL., FEBRUARY 7, 1947

THE FARMER AND THE MEDICAL SERVICE PROGRAM

I am quite conscious of the fact that doctors do not like figures—or should I say arithmetic. However, I do not know how to talk about "the farmer and the medical service program" without figures, so let's take the bad medicine first and get it over with. First, let us look at the farmers' ability to pay doctors' bills under normal conditions. During the 10-year period 1921–30 the net income of farm people was $200 per capita as compared with $800 per capita for nonfarm people. During 1931–40 it was $150 to $580. During 1945, which can hardly be considered a normal year, the per capita income of farm people averaged $740 as against $1,260 for nonfarm people. You may raise the objection that the farmer has had free house rent and free food, but that is not true, for those items have been calculated and added to his cash income to obtain the income as I have given it.

Thus we can see that the average farmer's ability to pay for adequate medical service is substantially lower than nonfarmers.

Next let us look at it from another situation. On the average, farmers live a substantial distance from cities or towns where medical and hospital service is available. They cannot help that. The vocation of raising the food the Nation needs requires some of us—lots of us, to live way off from "Main Street." Before the war in our 1,000 most rural counties there was only one medical doctor for every 1,700 people.

In our big cities there was one doctor for every 650 people. In most rural communities there are less than 2.0 hospital beds per 1,000 people. In fact 1,200 of our rural counties have no recognized hospital within their borders and these counties have a total population of 15,000,000 people. Hospital workers tell us that we should have 3.5 or 4.0 hospital beds per 1,000 rural people.

The shortage of doctors in rural communities is partly due to the fact that doctors like to live and practice where adequate facilities are available. It is partly because doctors do not like the inconveniences and hardships of country practice. It is partly due to income discrepancies such as I first discussed with resulting lower income for the doctors. No doubt there are many other causes.

Now let us look at the accident rate among farmers and those employed in industry. The accident death rate per 100,000 workers on farms during 1945 was 53; as compared with 19 in manufacturing industries. When it comes to less serious accidents, but those still requiring medical care, farm experience will show that most farm workers have one or more such accidents every year. Even the farm children are exposed to innumerable hazards. In considering farm accidents we must not forget that the farmer who suffers an accident is usually far from a doctor or a hospital while most industrial plants have medical service and hospitalization facilities on the premises.

Now, let us look at some of the results: Farmers live in the open country, get plenty of exercise, and should get plenty of good food. For generations we have believed that our strongest and healthiest boys came from the farm.

Figures released by the military service during the late war have awakened us with a rude shock. We found that the farm boy was not nearly so fit physically as the city boy. It was found in 1943, when 18- and 19-year-olds were being drafted, that for the country as a whole 25 out of every 100 were rejected, whereas for farm boys alone 41.1 boys per 100 were rejected. In addition, infant and maternal mortality rates are 25 to 30 percent higher in rural communities than in urban.

Thus we see that the high cost of adequate medical care relative to farm income and the lack of modern medical facilities in rural areas adds up to a real problem. When we add to this problem the abuses of overcharge and unethical practices that some doctors are guilty of, and which most of us have been the victims of, it adds up to an overwhelming demand for better medical service.

We appreciate the need for maintaining high standards in the medical profession, but the fact remains that over a vast section of America the cost of medical service has increased enormously and the availability of service has become poorer and poorer. Whether rightly or wrongly, we believe it is a simple statement of fact that the feeling has become more and more general that the medical associations, instead of devoting their chief efforts to the improvement of medical standards, have been more interested in eliminating competition in the medical field. Certain it is that medical service is not only much more costly, but much more difficult to secure, and rural America is rapidly getting up in arms over the inadequate service.

And so we have a very definite problem. It seems to us that the doctors ought to have many constructive suggestions.

By and large the answers furnished so far by the medical profession have been negative in character. We think the doctors should join in some practical positive action. We do not know what the answer is but we know that present conditions are not satisfactory.

More and more people are turning to cooperative medicine. It has many advantages, not the least of which is adequacy. It is preventive in character. It is more economical and does not require that farmers be classified as paupers in order to secure adequate service at prices they can afford. It combines the advantages of the specialization of group practice with the efficient use of personnel and facilities. However, in many sections we have faced a storm of resistance on the part of the medical profession against every effort to organize cooperatively to improve conditions, although happily this seems to be diminishing.

In this new field of cooperative effort there are many difficulties to overcome and generally speaking the best efforts that many communities have been able to put forth have not proved adequate.

Clearly, it seems to us that the situation is one demanding the best cooperative efforts of physicians and farm groups in working out a practical solution. We do not want to leave the impression that the physicians are solely responsible for an unsatisfactory situation. The health service, the schools, and the farm organizations all have their responsibilities. The point we have tried to emphasize is that we have been trying to meet the situation by the cooperative medicine route, but have not had much help; in fact have met a great deal of resistance. If there is a better way, let's have it. If not, let's all join to meet the growing need cooperatively.

I think I would be remiss if I did not comment on the situation as I see it today. With the inadequacies of the service, and the resistance against change, it is not surprising that more and more farmers are turning toward Government help and State control of medicine, including compulsory insurance.

My organization does not believe in State control of medicine; we believe there should be a better way. Nevertheless, we believe in adequate medical and hospital services, and if it cannot be found in some other way, I am very sure that the farmers will turn more and more to State control.

We feel that this is a joint problem. We do not believe the medical profession can ignore the needs of those whose occupation require that they live in the open country. Some way adequate medical service must be provided. If it cannot be provided any other way, I am confident that eventually farmers will seek State medicine. I am also confident that if the State once starts to furnish medical service for a portion of our population, it will spread to the cities and we will have a dual medical service system.

Summing up, there is a real problem which must be met if we are to avoid stateism in medicine. I feel that the medical profession must realize the necessity of furnishing adequate service and must join with others in providing a positive program which will bring results if we are to avoid State control.

Mr. Fichter. Every point does not need to be discussed here, but we would like to say something about the problem of cost of medical care.

Adequate modern medical care is very expensive, and many if not most farm families cannot afford it. Prepayment plans enable some to meet the cost of medical care, but there still remain many people who cannot afford to pay the premiums or subscription fees. For that reason we recognize that public funds must be used in some manner to help the low-income people, or some other system adopted.

We are opposed to means tests as a method of making public funds available to those who cannot afford to pay the whole cost of medical care. We believe that any person or family which makes a reasonable payment, judged on the basis of income and benefits received, for medical care on either an individual or group participation basis should be enabled to get adequate medical care without any public embarrassment. Such payment by the low-income people will not be sufficient to cover the actual cost and public funds will be required to supplement those payments.

We are not concerned solely with the problem of paying for medical care. We believe that more attention should be given to reducing the cost of medical care.

Equally important is the organization of medical services so that people will seek preventive rather than emergency medical care. Medicine should be organized to make the services of specialists more available and to provide for more consultation between doctors. We look with disfavor upon a proposal which may tend to perpetuate the present inefficient medical organization, and we might well find an undue burden upon the taxpayers.

The National Grange feels that cooperative medicine is one system that does much to put medical services on a more efficient and rational basis. Doctors are generally hired on a salary basis and every effort is made to use the doctor's time efficiently. Nurses and other auxilliary personnel are used to save much of the doctor's time. Group practice seems to be the rule and this allows for some specialization and consultation among the doctors. As the system grows there will be more of this.

Cooperative medicine tends to provide preventive rather than emergency medical care. People pay their medical bills in advance and do not have to hesitate when they become sick hoping they will get well without seeing the doctor so as to save some dollars. Often the patient does not get well; and by the time the doctor's services are sought, the disease may be in an acute state unresponsive to treatment.

Cooperative medicine has been very successful in many rural areas in making excellent medical care available at a price most farmers can afford. Farmers are beginning to see what they do for themselves by providing medical care on a cooperative basis.

We are very strong in our belief that control of plans or programs for the payment of medical care should be largely in the hands of the consumers. The American people have been very wise in adopting safeguards to prevent lay interference in the actual practice of medicine but payment for medical care is another matter.

We also favor as much local control and administration as feasible in the administration of voluntary or Government health plans and programs.

(The resolutions referred to are as follows:)

HEALTH PROGRAM THE NATIONAL GRANGE ADOPTED NOVEMBER 1946

Whereas sound health of the people is essential for national strength and social progress; and

Whereas sound health is a humanitarian consideration: Therefore be it

Resolved, That the National Grange adopt the following health objective:

That rural people share fully in the benefits of modern medical science regardless of their economic status, race, or geographical location.

To accomplish this we recommend that the Grange seek to bring about the following conditions:

(1) Improved accessibility, availability, and quality of hospital and medical facilities in rural areas.

(2) An increased number of well-trained physicians with proper distribution in rural areas.

(3) A medical cost payment system which will enable all people to secure modern medical care without undue burden.

(4) A rural citizenry informed as to what constitutes adequate medical care and its importance and a citizenry informed as to how it can best be secured for all.

(5) Adequate public health services.

(6) Increased research in the various fields of health.

In the effort to bring about these conditions we make the following recommendations:

(1) To provide adequate medical and hospital facilities for rural people we recommend—

- (*a*) That all granges endeavor to acquaint their respective communities with the purpose and operation of Public Law 725, known as the Hospital Survey and Construction Act.
- (*b*) That the National Grange favor appropriation by the Congress and by State Legislatures to put the Hospital Survey and Construction Act into effect.
- (*c*) That the National Grange and the State granges work to establish a subcommittee of rural leaders in each State to advise with the State hospital council which will be set up in connection with administration of Public Law 725.

(2) To increase the number of well-trained physicians and to bring about a better distribution of physicians we recommend—

- (*a*) That States provide scholarships to make it possible for able young men and women to study in the medical school of the State or of a neighboring State under conditions which will cause them to start practice in rural sections after they have been trained.
- (*b*) That each State should prevent monopolistic abuse in determination of medical-school enrollment.
- (*c*) That adequate medical-school facilities should be provided by the States.

(*d*) That local communities make known their need for a well-trained physician to the medical societies and seek to induce a physician to come to the community.

(3) To meet the problem of medical costs we recommend—

(*a*) That because of the unknown and unpredictable cot of illness rural people should develop a comprehensive form of prepayment plan for hospital and medical care.

(*b*) That the Grange support and promote the establishment of cooperative hospital and health centers in rural areas, particularly in connection with Public Law 725.

(*c*) That administration costs of voluntary or any public health program be held to a minimum.

(*d*) That where the rural people cannot afford to pay the total cost of adequate medical care public or private funds be used to supplement what payment the individual or family can reasonably make.

(4) To inform the people of the importance of adequate health care we recommend—

(*a*) Introduction of comprehensive health subjects in our primary and secondary schools and colleges.

(*b*) The distribution of health literature to the Grange membership.

(*c*) Preparation of health articles for the various Grange papers.

(*d*) The addition of a health specialist on the staff of the extension service of every State to work with county agents and rural health organizations.

(*e*) That granges encourage a study of the forthcoming report of the Commission on Hospital Care and of a pamphlet dealing with the economic aspects of the eradication of human tuberculosis, now in process of preparation by the National Planning Association.

(5) To work toward an adequate public-health program we recommend that public-health services be established in every rural section to improve sanitation, prevent and control disease, and promote good health.

(6) We recommend that the Grange support the expansion of medical and dental research programs at the Federal, State, and local level.

(7) To promote the attainment of our health objectives through our program we further recommend—

(*a*) That the National Grange join with other organizations and agencies in sponsoring a regional workshop on health, as recommended by the Conference Committee on Rural Health.

(*b*) That the farm organizations attempt to seek agreement on legislation necessary to make it possible for all the people to avail themselves of adequate health facilities and medical care.

(*c*) That the master of the National Grange be authorized to appoint an interim committee on health, the duties of which shall be to compile information on health activities sponsored by the granges throughout the land; to work with similar committees of other national organizations and agencies in developing study and research in health matters; to furnish information to the master of the National Grange, between sessions, regarding the administration of the Hospital Survey and Construction Act; and to perform such other services as suggested by the national master, and that the committee present a report at the next session of the National Grange. Said report shall be referred to an appropriate sessions committee.

(*d*) That a committee on health be appointed in each State, pomona, and subordinate grange.

We recommend that any program to bring about adequate medical care give due consideration to the following principles:

(1) Every individual should put forth a reasonable effort to meet his own health needs either on an individual or group participation basis.

(2) Outlay of public funds should be kept as low as is consistent with the attainment of our objective.

(3) Local control and administration should be maintained to the full extent feasible.

(4) Means tests for those unable to meet the cost of adequate medical care should be avoided if at all possible, and, instead, a reasonable payment should be required of every individual or family in view of their income status and benefits received.

(5) Medical payment plans should be primarily controlled by the consumers or patients.

Adopted.

Senator DONNELL. I recall in the earlier portion of your testimony that you stated, as I understood it, that the Ohio State Grange has not acted upon the subject of compulsory health insurance; that is correct, is it not?

Mr. FICHTER. That is correct.

Senator DONNELL. I have glanced through a portion of the health program of the National Grange adopted November 1946, and I do not observe any reference there in that program to compulsory national health insurance.

Mr. FICHTER. That is right.

Senator DONNELL. Or compulsory State insurance either, for that matter; that is correct, is it not?

Mr. FICHTER. Yes, sir.

Senator DONNELL. And I notice you comment on the importance of cooperative medicine and emphasize the strength of your beliefs, controlling beliefs, for medical-care program should be largely in the hands of consumers; I gather from that you favor every possible effort for people themselves, the consumers themselves, to work out plans for the development of a cooperative medicine; and while your organization has not passed upon governmental compulsory health insurance, I would infer that your reasoning is along the line rather of the importance of development of cooperation among consumers rather than governmental interference; am I right in that conclusion?

Mr. FICHTER. Well, I think I might say that as we conceive of it there are three ways by which this cost of medical care can be shared and by which medical care can be made available to people who are not now receiving it.

One is through these voluntary cooperatives; the other is through compulsory insurance; and the other is through public assistance provided through taxes.

And as I tried to point out in my statement, we feel that every possible opportunity ought to be given to the cooperative plan on a voluntary basis, and before we have to give up and say that we have to do it in a way that would be controlled by the Government. That is the reason that I raised some questions about this Senate bill 545.

As I study it, it appears to me as being a method of using that third method I mentioned, the State through having this thing done on a public basis with money collected through taxes and the State administering the program, and while it does it for only a part of the people, those whose income is not sufficient to take care of their own needs, it nevertheless seems to me to commit us to a State program of health, and if we were to follow the parallel of our school system it is quite likely that after starting on this program we might later have the question raised as to whether we should extend it to the whole people.

Our public schools started on the plan that they were made available first to the children of the poor, the paupers; it was a kind of matter of low income if you went to a public school. Later on, public schools were extended to include all children.

Now, I think in facing this whole matter of health it is quite proper for us to consider which of these three directions we want to go, the voluntary cooperative, the compulsory health insurance, or the State doing it.

Senator Donnell. And you favor every possible exploration of the cooperative plan before we embark on either of the other two plans.

Mr. Fichter. That is right.

Senator Donnell. And am I correct in assuming this, that if recourse must be had to some governmental plan, that the plan of compulsion would be about the last course that you would tend to advocate?

Am I right in that statement?

Mr. Fichter. That is right.

May I say, when this bill first came up for the attention of those interested, I was of the opinion that we were going to start in a direction of maybe providing care for all the people, but as I have studied it more closely, I have come to see some things in it that I did not see in the beginning.

If we adopt this thing, we are committed to a State plan but we are limiting it to the poor people. Now, I think we ought to know definitely whether we want to go into that, and it is compulsion, just like our public schools are a matter of compulsion, inasmuch as everybody is required to pay taxes, and our highways operate on the same principle, and I am not arguing whether we should or should not take that position. I think we should face the possibility of taking care of medical indigents.

There are several phases in it that do permit a good deal of studying on that part. Take the matter of Federal control on page 18, lines 8 to 10, or page 32, lines 14 to 19, and there is a rather interesting phase in the part of the dental part, page 31, lines 8 to 17. It provides ways by which the States may make examinations for dental needs and also care for those dental needs.

Now, we may say, well, that is all going to be optional, yet we did not know what interpretation might be given on it by the administrator, that the children of those low-income people might be required to submit to dental care.

I was interested in what the doctor from Montana pointed out, that we have a right to decide whether we do not want to have dental care forced on us, to have our teeth extracted.

Yet, I can see the possibility in this of a child being required to have teeth extracted. I have seen it in the matter of different things done under the school system. For example, children have been required to do these things, required to submit to vaccination, and they have either got to do that or go to some other school. So I think there are a good many things in it that we ought to think about very carefully.

Senator Donnell. Well, we are very glad to have your views, and you have presented some very important subjects there, and we are glad to have your comments on them.

Mr. Fichter, when you appeared last year before the Committee on Education and Labor you were there on behalf of the National Planning Association. You are not appearing for that organization today?

Mr. Fichter. I am appearing as chairman of the interim committee on health of the National Grange.

Senator Donnell. Very well.

I understand you wish to divide your time with Mr. Halvorson?

Mr. Fichter. Yes, sir.

Senator Donnell. We will hear from him now.

Thank you, Mr. Fichter.

STATEMENT OF LLOYD C. HALVORSON, ECONOMIST, THE NATIONAL GRANGE

Senator DONNELL. Mr. Halvorson, you are not a doctor?

Mr. HALVORSON. No, sir; I am a Ph. D. in agricultural economics.

Senator DONNELL. You are not a medical doctor?

Mr. HALVORSON. No, sir.

Senator DONNELL. Will you state for what organization you appear and something of your background?

Mr. HALVORSON. I am an economist for the National Grange, and my training in agricultural economics was at the University of Minnesota and Ohio State College. I have been in the National Grange since September 1945.

Senator DONNELL. Now will you proceed with your statement?

Mr. HALVORSON. Mr. Fichter has presented the broad thinking of the National Grange on the rural health program. I would like to comment on certain provisions of S. 545.

Title I provides for a National Health Agency. We can see no need for a separate health agency and believe it will only complicate the present organization of the Federal Government. We do favor bringing the health functions of the Federal Government together into one unit, but we feel that such a unit should be grouped with the other welfare units under one administration—at present the Federal Security Agency.

Section 101 (c) of title I specifies that the Administrator of the National Health Agency shall be a doctor of medicine. We believe that the prime consideration in filling this position should be demonstrated ability of a person as an administrator to carry out health programs—not the ability of a person to diagnose disease, to prescribe medicine, or to wield a surgeon's knife. In fact, we fear that if a doctor of medicine fills this position of Administrator, his proprietary interests in the practice of medicine might conflict with the general welfare. We do recognize, however, that many doctors of medicine are excellent public administrators.

On page 9 of the bill, section (c) provides that the Director of the Office of Medical and Hospital Care Services shall be a doctor of medicine and further requires that he shall have had at least 5 years of active medical practice. We have the same fears here as we have in regard to requiring the Administrator of the National Health Agency to be a doctor of medicine. In fact, the requirement of 5 years' practice increases our fears. We also feel it unsound to require the Director of the Office of Dental Care Services to be a doctor of dental surgery with at least 10 years of active practice. If this health bill provided for the dispensation of medical or dental services we might agree, but this bill deals primarily with the payment or economics of medical care.

We favor the extra authorization and appropriation for public-health functions provided for in section 203 (c) of title II of S. 545. About one-third of the rural counties are without adequate public-health services.

Part B of title VII, S. 545, provides for the use of Federal funds to help furnish medical care to the low-income people who cannot meet the whole medical cost themselves. Because so many farm people fall in this category, we are very much concerned with this part of the bill. If any Federal program of financial aid for medical care is to be adopted, we are certain, as indicated by Mr. Fichter, that we do not want to see a means test used which would publicly embarrass the applicant or patient. We recognize that some method must be worked out to supplement the medical payment of the low-income people. We would like to see safeguards written into the bill which would assure us that this would be done without public embarrassment to those low-income people. We hold this view because any test which would publicly embarrass an individual or family would prevent many farm people from availing themselves of the public funds and the rural-health situation would continue to grow worse. Before we could favor any health program involving the use of public funds, we would need to be assured that the money would be available on a democratic, self-respecting basis to supplement what payments the low-income people can reasonably be expected to make.

On page 18, section 712 (a) (4) provides:

> Such program may also provide for the furnishing of such services [medical care] to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State, to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor.

One of the criticisms of the bill is that it places too much control in the hands of the medical profession. We feel that any medical prepayment plan should primarily be controlled by consumers or patients. Some States have legislation restricting the right of consumers to form their own health plans, thus throwing the complete control to the medical profession. This bill would tend to strengthen that control. We believe that it would contain a provision making the aid available only to those States which make it possible for the patients or consumers to operate their own health plans under their own control if so desired.

Section 712 (a) (5) requires the States to match the Federal funds. The poorer States might find themselves unable to avail themselves of the full benefits of this program unless this section is changed so as to allow the poorer States to get the Federal funds, if they put up only 50 percent as much as the Federal funds. This percentage could be graduated upward as the per capita income of the people in the States equals and exceeds the national average.

Section 715 (b) specifies the makeup of the National Medical Care Council. We feel that at least four out of the eight appointed members should represent the consumers of medical services and should be familiar with the needs for medical and hospital care in urban or rural areas. Again I wish to say that this program is primarily concerned with the use of the people's money to pay for medical care so that all can enjoy modern medical care. This program is not concerned with the techniques for diagnosis, surgery, or therapy. We want to feel sure that the people who direct a health program are concerned with the public getting the most for its money.

Title VIII, which provides for dental-health services, so closely parallels title VII that the comments we would make on title VIII correspond to those made on title VII. I note that in the National Dental Health Council four out of the six appointed members "shall be doctors of dental surgery." Here, too, we want to see that at least three out of the six members represent the consumers.

Title IX of the bill provides for research and training in the dental field. We favor research in the dental field and also the efforts to train adequate personnel.

The National Grange also favors additional research in all the other fields of health; not only in the dental field. Cancer, infantile paralysis, tuberculosis, heart disease, diabetics, and many other diseases are equally important health problems.

Senator DONNELL. Mr. Halvorson, have you studied S. 545 and S. 1320?

Mr. HALVORSON. I have not studied S. 1320.

Senator DONNELL. So you are not prepared as an economist, I take it, to express an opinion as to the cost of S. 1320 without studying the matter.

Mr. HALVORSON. No; but we do feel it would be—that is the reason we favor cooperative medicine to provide adequate care and reduce costs.

Senator DONNELL. You have no figures in mind as to the probable cost of S. 1320 per annum?

Mr. HALVORSON. No, sir; I have not.

Senator DONNELL. Where are your headquarters?

Mr. HALVORSON. National Grange Building, 744 Jackson Place NW, Washington, D. C.

Senator DONNELL. How long have you been with the National Grange?

Mr. HALVORSON. Since September 1945.

Senator DONNELL. Did you not appear before this committee last year?

Mr. HALVORSON. Fred Bailey appeared on S. 1606 and I was with him, and there were a few questions asked of me.

Senator DONNELL. I thought you had been before the predecessor committee, the Education and Labor Committee.

Do you have any report as to where cooperative medicine is being tried out and is working well?

Mr. HALVORSON. Yes; in the rural sections. Elks City, Okla., was one of the first plans, and now Amherst, Tex., is another plan. And, of course, in Washington, D. C., we have group health which is a city plan working very favorably. In the Pacific Northwest is where the cooperative-health movement is taking root in the National Grange, and also in Texas the Grange is interested in it. We have not made a survey of the Grange activities, but the other States are interested in cooperative medicine and we expect some activity in that field.

Senator SMITH. Do they differ substantially from such plans as the Blue Cross plan?

Mr. HALVORSON. Yes; more comprehensive than medical care.

Senator DONNELL. Blue Cross expanding into Blue Shield.

Mr. HALVORSON. That is only surgical care.

Senator DONNELL. Wider reaches in Massachusetts, for example, where they are trying to make it more inclusive.

Mr. HALVORSON. The big difference between cooperative medicine and prepayment plans of that nature is that cooperative medicine involves hiring the doctor to perform medical services for the patients and as it was indicated by Mr. Fichter, the consumers setting up their own health plan, hiring the doctor, and they are able to effect economies.

Senator DONNELL. We would be very much interested if you have any outline or statement of just the way the cooperative is set up, that is, in the rural areas. That might be an approach that other plans do not reach.

Mr. HALVORSON. Farm people are vitally interested in the cooperative movement. They understand it and it is a way in which they participate in solving their own problems. Farm Credit Administration has made studies of these cooperative hospital plans or comprehensive consumer health plans that are available.

Senator SMITH. You are familiar with the hospital bill we passed last year? Under that we are trying to reach the needs of the rural areas.

Mr. HALVORSON. Very healthy people.

Senator SMITH. We hope successful, and I think your cooperative plan might fit into that.

Mr. HALVORSON. What we are trying to do——

Senator SMITH. I am interested in your suggestion about cooperatives.

Mr. HALVORSON. We think by having cooperative groups it is one way to get money to equal, to match Federal funds, to match facilities.

Senator DONNELL. Do you think any farm groups would be able to finance these cooperative organizations in groups solely or would they require some governmental participation?

Mr. HALVORSON. It would still require some public funds to supplement the payment that the low-income people are able to make. In other words, some areas, the communities where the people can meet the whole costs themselves—there are some of those—and there are other communities where there are more of these people who cannot equitably meet the cost.

But we do think that in a number of areas and for some people probably in most areas some public funds will be required to supplement what payments they can make.

Senator DONNELL. We are very grateful to you as well as to Mr. Fichter for your testimony and appreciate your coming this morning.

The next witness is Miss Elizabeth S. Magee, general secretary of the National Consumers League.

Miss Magee, I trust you will not be alarmed or discomfited if, when 12 o'clock arrives, we recess for a few minutes. We have a Senate rule that requires that no committee may be in session while the Senate is in session without the consent of the Senate. We will endeavor to secure consent which we anticipate will be forthcoming.

Miss MAGEE. I thought probably you wanted me to be brief.

Senator DONNELL. Not at all. We will be very happy to have you proceed.

STATEMENT OF ELIZABETH S. MAGEE, GENERAL SECRETARY OF THE NATIONAL CONSUMERS LEAGUE, CLEVELAND, OHIO

Miss MAGEE. My name is Elizabeth S. Magee. I am general secretary of the National Consumers League with headquarters in Cleveland, Ohio. Our State branches are to be found in Connecticut, Delaware, Kentucky, Massachusetts, Michigan, New York, Ohio, and Rhode Island.

Senator Donnell. Last fall Dr. Alice Hamilton appeared?

Miss Magee. Yes; at that time it was known as the National Consumers League, as now.

Senator Donnell. Did we have the Consumers League of Ohio represented last year before the Education and Labor Committee?

Miss Magee. There may have been a statement filed but certainly not a personal appearance.

Senator Donnell. On page 970 of the hearings last year appear the minutes of a public hearing sponsored by the Consumers League of Ohio. Now, Is that a subordinate body to the National Consumers League?

Miss Magee. Yes.

That hearing, however, was more comprehensive in that it included—it was kind of a mock hearing if you want to call it that.

Senator Donnell. A what?

Miss Magee. A mock hearing. There were no Senators present. It was a hearing in which representatives of various community groups apeared and spoke on the subject of health insurance in relation to their experience locally and to some extent some of the data similar to what was brought in by Mr. Fichter was brought in from the State of Ohio. Senator Murray happened to be included in it soon after and at his request the report was filed with your report of hearing.

Senator Donnell. Tell us briefly if you have not already done so, the membership of the National Consumers League.

Miss Magee. I am sorry, I cannot give you complete statistics but I will be glad to file it with the committee.

Senator Donnell. How many, approximately?

Miss Magee. There are 1,500 members of the national organization scattered in every State; in addition, the State branches have varying sizes, none of them very large.

But I do not have the complete statistics.

Senator Donnell. Now, the 1,500 members of that organization; do you mean by that those members are by themselves or how?

Miss Magee. Individuals who support the national organization.

Senator Donnell. Fifteen hundred persons then belong to the organization for which you speak?

Miss Magee. Yes.

Senator Donnell. Then there are also State bodies, subordinate bodies, and you are not able at this time to give us the aggregate memberships of those State bodies?

Miss Magee. That shifts from year to year and we do not have the figure; but we could get the figures and file them with the committee.

Senator Donnell. Do you have any idea as to how many?

Miss Magee. Most they had was an average of around 100 each. It has never been a large organization.

Senator Donnell. Miss Magee, I lost your answer.

Miss Magee. I said I presume some State organizations would have about 100; some less, some more. Then I went on to say it has never been a large organization because pioneer organizations that are supported by people who believe in this kind of thing are not, perhaps, or would not have the mass appeal that some organizations have.

Senator Donnell. Will you proceed with your testimony?

Miss MAGEE. By nearly 50 years of work for protective regulation of conditions of work of women and children in industry, minimum wage laws, unemployment compensation, and other social legislation, our organization has given proof of its belief that equality of opportunity for fair labor standards must be accorded to all. It has hailed measures of social security as bulwarks against the storms of today's complex world. With the proposal to extend social security into the field of health, the National Consumers League finds itself in hearty agreement. Last spring, 1946, our president, Alice Hamilton, M. D., appeared before the Senate Committee on Education and Labor to speak for S. 1606. As she said at that time:

> In 1938, 1939, and 1941, delegates to our annual meetings have voiced their strong approval of the principles of the national health program and urged immediate legislative action, especially with regard to compulsory health insurance, on a Federal basis, available to all income groups.

At our annual meeting on January 18, 1947, in New York City, the following resolution on the subject of health was adopted.

Senator DONNELL. How many persons were present at that meeting?

Miss MAGEE. Probably 400 at the time this resolution was adopted.

> Whereas sickness is the most constant cause of poverty and dependency; and
>
> Whereas wage earners and their families need protection against the loss of income during periods of temporary or permanent disability; and
>
> Whereas there should be available in all parts of our country and for all groups of the population the protection of adequate public health services, and the opportunity to secure adequate care in sickness; Therefore, be it
>
> *Resolved*, That the National Consumers League renew its support of compulsory health insurance; and be it further
>
> *Resolved*, That we support social insurance to offset the loss of earnings among workers who are temporarily or permanently disabled.

Before presenting the main body of my testimony, I should like to emphasize one special point. The National Consumers League feels itself an appropriate spokesman for the point of view of consumers who believe that under our democratic system the people who receive and pay for a service should have a voice in formulation of nonprofessional policy and in regulation of its administration. We take great satisfaction in these specific provisions in S. 1320, and we register our objection to their omission from S. 545.

In general, however, we oppose the National Health Act of 1947 (S. 545) introduced on February 10, 1947, and support S. 1320, the National Health Insurance and Public Health Act of 1947, introduced on May 20, 1947, for the following reasons:

We are greatly interested in the effort at this time to inaugurate a broad program of medical care designed to meet the needs of the great majority of the people of America. We believe that the level of the Nation's health is clearly below what could be achieved were the fruits of scientific advance brought to bear on human problems early and often according to need. We are not discounting the public ignorance of the danger signals or of the resistance to education for health, but we are constantly brought up against the simple fact that demand for adequate care is not regulated by the patient himself but governed by his ability to meet the cost.

The proposals of this bill (S. 545) which you are considering do not apply to the great majority of American citizens who are in the low-income brackets. The majority are not indigent but citizens imbued with the self-respect which is born of self-support. Should their cases be examined for medical or dental care supplied by the Federal-State funds under this bill, they would be classified as ineligible. It is the small farmer, the industrial worker, those on modest, fixed salaries, the self-employed with incomes under $3,000 a year who are in need of comprehensive, spreading-of-the-cost insurance plan. By such a method they would not only pay their own medical costs but their share of the improvement schemes for the benefit of the whole Nation.

If I may interpolate at this point, I would like to speak of a personal experience we had in the Consumers League in Ohio in attempting a number of years ago in connection with the minimum-wage law to draw up a budget of the cost of living for workingwomen in the city, the city of Cleveland. We could, through a survey of the situation, find out approximately what it cost a girl to live away from home, rent a room. We surveyed the restaurants, discovered about how much a girl who had to eat away from home all the time would spend, and eat a fairly balanced diet. We could get at what was the minimum of, let us say, recreation. We know what carfare cost.

When we came up against medical and dental care we were completely stumped. We discussed this with the medical association of the city; we interviewed individual physicians; and all of them gave us practically the same answer, that is, that medical care you cannot budget within a weekly minimum wage.

Now, these are girls working primarily in intrastate; the Federal act takes care of interstate. Those were girls and women working in department stores, beauty parlors, dry-cleaning establishments; and I think that is one of the first things that made us realize how difficult for the self-supporting and self-respecting working girl the cost of medical care is and how valuable it would be if there were a way by which this could be budgeted ahead of time and paid for regularly out of wages received.

In a city like Cleveland, of course, the Institution of Hospital Services Association has been a tremendous help to that group as it has been to many of us in the professional group because for a comparatively small amount we are able to assure hospital services, but of course it does not cover the extraordinary expenses of operations or medical care for a protracted illness, and I think I do not need to tell you that all the studies that have been made of budgets of workers' families show that those catastrophic expenses are the things which set back workers in their budgets more than anything else.

It is not my purpose to discredit the plan of S. 545 for assisting the medical needy as much as it is my desire to uncover the sterile thinking in which it was conceived. It finds the indigent and treats him. Suppose he is unemployed and later secures a job, S. 545 would do nothing to help him by arranging small, regularized payments, to climb out of even the partially indigent class. The genius of the national health insurance scheme for medical care, on the other hand, is displayed in its financial aspects, by its ability to prevent the low-income worker from ever slipping into the indigent class.

The eligibility of those who would benefit from S. 545 must be proven by a means test. You have undoubtedly heard vigorous outcry against this—its humiliating effects—the bitterness it would breed. Shall it be said of the only great country to emerge from this world conflict, richer in national income and in productive capacity, that it sought to remedy the condition of its least fortunate by treating their bodies while it broke their hearts? The manner in which we conduct our operations is of the utmost importance to the final end achieved. We feel very strongly that only on solidly democratic foundations can a national health program be built. By democratic foundations we understand equality of opportunity to receive full medical promotion of health and prevention and treatment of disease for all of the people throughout the length and breadth of the land. We support the measure which includes in its design care of the needy by payment from the States into the insurance fund of premiums which the needy could not meet themselves, which I understand is in S. 1320. These individuals thereby would qualify for the same quantity and quality of care as the established wage earner. Again, that is what we mean by democratic foundations—the recognition of the dignity and worth of every human being and the invigorating and healing influence for him of that sense of security which eligibility for nationally accepted benefits and freedom from fear of their costs would bring.

The plan to bring the "American way" of greater abundance within the grasp of an ever-increasing proportion of the whole people can never be realized if we do not proceed resolutely to develop a more virile people to live this life. Full employment, adequate educational facilities, conservation of natural resources are all essential means to the end, but the conservation which America makes of its human resources surely takes percedence over all else.

The critical eyes of the world are on our country to discover whether our systems can be made to prevail. If we do not execute a national-health program designed for all, with all sharing in the expense, and all in the benefits, we shall be left without national standards for conditions of service, for hospitals, for specialists, and for the method of payment in each instance. We shall have no provisions for our mobile population, and we shall neglect the obvious economies which can be achieved through a unified collection of national funds. Weighted down by such handicaps, how can we hope to win against the forces which today sap our vitality while the weapons of science remain unused in their sheaths? Today we are not fighting for civilian fitness with all the weapons at our disposal. We do not estimate the price we pay for neglect or undertreatment in prevention and cure. Nor do we think of the increase in human assets on the credit side of our national balance sheet which would accrue if we took hold of these weapons and used them boldly—not alone for ourselves but for our neighbors across the way, and across the State line, and beyond.

S. 545 appears to us inadequate even for that section which it proposes to cover, the indigent, because of its undemocratic approach and its insufficient scope. There is a real danger in its specious appeal to the "charity-minded." We do not want charity. We want the legislation which would mitigate the need for charity and institute insurance against it.

Finally, we do not think it farfetched to relate the physical and mental stability of America to the part she is able to play in international affairs. Support for new ideas and new techniques, and zest for cooperation are expressions of a dynamic people, mature in their responsibility and young in their willingness to respond to the challenge of a one-world goal. Peace is still some distance away. Better health for the Nation can help to bring it nearer. The people look to Congress for leadership.

Senator DONNELL. Miss Magee, referring back for just a moment to the matter of the membership of your organization, I note in the testimony of Dr. Hamilton, at page 979, last year, it says:

> Our membership has never been large. I suppose it is about 5,000 members, but we have had more of an influence than those numbers would indicate, because we have been able to secure the cooperation of a number of very well known authorities in the field of philanthropy and economics.

Do you think Dr. Hamilton would be in possession of facts as to the total membership?

Miss MAGEE. I am afraid not; she lives in Connecticut and our office is in Cleveland, and she did not know the question was going to be asked, and she undoubtedly was including people in State branches which she must have had in mind when she said that.

Senator DONNELL. What I am getting at is that, everybody considered, the total number—State branches and all—do you think it would run over 5,000?

Miss MAGEE. Yes, sir; definitely, because we have 10 branches and 1,500 in the national membership; I can vouch for that because I am head of the national office.

Senator DONNELL. I see. All right. Now, Miss Magee, I want to ask you also in the statement that you have given to us this morning, was that prepared by yourself solely or in collaboration with other representatives?

Miss MAGEE. In collaboration with members of my staff.

Senator DONNELL. Can you tell us who?

Miss MAGEE. Mrs. Jeanne Pilcher.

Senator DONNELL. Where does she live?

Miss MAGEE. In Cleveland.

Senator DONNELL. Miss Magee, what is your own educational background and experience?

Miss MAGEE. My educational background includes a B. A. degree from Oberlin, master of arts from Columbia University.

Senator DONNELL. You are not a medical doctor?

Miss MAGEE. No, indeed.

Senator DONNELL. And Dr. Hamilton is?

Miss MAGEE. That is right; she was a professor in Harvard University Medical School for a number of years.

Senator DONNELL. Now, I wanted to ask you——

Miss MAGEE. It happens that Mrs. Pilcher is educated in medicine.

Senator DONNELL. I notice in the course of your testimony that—

> the proposals of this bill, S. 545, which you are considering do not apply to the great majority of American citizens who are in the low-income brackets.

What do you mean by that statement?

Miss MAGEE. I mean by that more or less the same thing that the economist from the Grange or someone else this morning indicated;

namely, that such a large majority of people are in the group that, say, if you want to take $3,000 as a line of income——

Senator DONNELL. This bill does not take any such figure as——

Miss MAGEE. No; but I would take that as saying the people below that cannot budget the cost of their medical care and therefore I say that if you limit it to the indigent, it does not take care of the majority of low-income groups. By "low income" I do not mean poverty.

Senator DONNELL. Have you found the word "indigent" in S. 545, from beginning to end?

Miss MAGEE. Certainly the part in relation to State plans indicates the necessity of need.

Senator DONNELL. I will read you what it says about the Statewide program. I am reading from page 18, and I quote from it beginning with the word "designed"—

> Designed and calculated to provide within five years hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such; and periodic physical examinations for all children in elementary and secondary schools in the State.

In the first place, as to periodic physical examinations, you observe that applies to all children in the elementary and secondary schools in the State.

Miss MAGEE. Not the care, but the examination.

Senator DONNELL. Yes; the examinations—that is what I am talking about. But as to the services, both hospital, surgical, and medical, that are to be applicable to all those families and individuals in the State having insufficient income to pay the whole cost of such.

Now, how do you know that that does not include the great majority of the American citizens who are in the low-income brackets?

In the first place, what is low-income brackets according to your definition?

Miss MAGEE. That shifts with the cost of living, Senator.

Senator DONNELL. Very obviously it would.

Miss MAGEE. But I think there are some research figures that certainly all the groups below $3,000 a year find it difficult to pay the entire cost of medical care. I believe there have been such studies made.

Senator DONNELL. Have you made any statistical study, or has your organization made any statistical study, of how many American citizens there are in what you call the low-income bracket?

Miss MAGEE. No; we have made no such study, but there are those statistics available for use from the Bureau of Labor Statistics and other sources.

Senator DONNELL. Did you have those statistics available when you wrote——

Miss MAGEE. As I say, I think we were referring in part to the testimony given by Dr. Hamilton last year in which she mentioned those income brackets. I did not look them up afresh.

Senator DONNELL. You did not?

Miss MAGEE. No; but I am sure that was what was in mind.

Senator DONNELL. Do you know whether Mrs. Pilcher looked it up?

Miss MAGEE. I imagine she did.

Senator DONNELL. Do you know whether she did?

Miss MAGEE. I do not.

Senator DONNELL. Your organization has not itself made any survey at all to determine how many American citizens are in low-income brackets?

Miss MAGEE. We would not need to.

Senator DONNELL. That is correct, is it not?

Miss MAGEE. And you have no private organization——

Senator DONNELL. I say you have not; is that correct?

Miss MAGEE. That is right.

Senator DONNELL. And you state that the term "low-income brackets" varies in accordance with the cost of living?

Miss MAGEE. That is right.

Senator DONNELL. Then how do we know what your figures are or what you mean here by low-income bracket?

What did you mean, as a matter of fact, when you used the term "low-income bracket"?

Miss MAGEE. What I mean is that the conception, as I read this bill—and I have read all of it, S. 545—and as I read the amounts appropriated and the general plan, and as I have read some of what Senator Taft said about it in his testimony and his statement that it is to deal with the people who would have to have a means test—I mean, who would prove to somebody that they would not have enough money to pay their bills—it seems obvious on the basis of general acquaintance with great groups of workers whom we know out of experience and our studies that have been made cannot budget expenses for medical care—that those groups are greater in number than could be met by this kind of a limited aid to the needy.

Senator DONNELL. You have not answered my question as to what you mean by the term "low-income bracket" in this statement. Can you tell us what you mean there?

Miss MAGEE. I think I would mean under $2,000 or $2,500 a year.

Senator DONNELL. Which; $2,000 or $2,500?

Miss MAGEE. Twenty-five hundred; I think that is low-income bracket.

Senator DONNELL. Is that what you meant when you wrote this?

Miss MAGEE. We meant something more general, Senator. I do not think we were submitting statistics or statistical tables, obviously.

Senator DONNELL. You are making a statement here on a subject of a good deal of importance, and when you say that—

> the proposals of this bill * * * do not apply to the great majority of the American citizens who are in the low-income bracket——

Miss MAGEE. People between the indigent and those who can take care of themselves in these extraordinary expenses, you see.

Senator DONNELL. Thus far——

Miss MAGEE. If you would like to have me submit statistics in support of that later, I would be glad to.

Senator DONNELL. No; I am asking what you mean in your statement, Miss Magee—you and Mrs. Pilcher, in this statement—and I want to know just what you mean when you make a statement like that. "The great majority of American citizens who are in the low-income bracket." You have arrived at $2.500 as the figure; everything below that—everything below that is low income.

Miss Magee. For a family; certainly.

Senator Donnell. For a family. Now, how many American citizens are there in this bracket?

Miss Magee. I do not have those statistics.

Senator Donnell. Did you have them when you prepared this?

Miss Magee. We have those in the office.

Senator Donnell. Did you have them before you when this statement was prepared?

Miss Magee. We had them in our office. I do not think they were consulted.

Senator Donnell. You did not consult them, did you?

Miss Magee. I did not consult them last week.

Senator Donnell. Any time?

Miss Magee. I have consulted them frequently.

Senator Donnell. What is about the percentage as to how many American citizens are in a bracket of less than $2,500 a year income per family?

Miss Magee. I would guess about 50 percent.

Senator Donnell. I am not asking you to guess.

Miss Magee. I have no statistics in front of me.

Senator Donnell. Do you have any recollection of them, Miss Magee?

Miss Magee. No; I do not.

Senator Donnell. Do you have any recollection of them at all?

Miss Magee. I have answered that I have no statistics with me.

Senator Donnell. I am talking about recollection.

Miss Magee. I do not carry those statistics in my head.

Senator Donnell. Therefore, you cannot tell us what is a majority. If you do not know what the 100 percent is I do not think that sentence helps us very much.

Now, Miss Magee, did you actually prepare that sentence at all or did Mrs. Pilcher do it?

Miss Magee. I think you know the way in which most statements are prepared in original draft.

Senator Donnell. Whether I know or whether——

Miss Magee. The original draft was prepared which I corrected and amended.

Senator Donnell. Who prepared the original draft?

Miss Magee. I said Mrs. Pilcher did.

Senator Donnell. She did?

Miss Magee. That is right.

Senator Donnell. She prepared the entire statement and you went over it and made certain corrections.

Do you know what corrections you made?

Miss Magee. I remember some of them. I took out a sentence.

Senator Donnell. But that is her sentence?

Miss Magee. That is right.

Senator Donnell. Can you tell us of any particular thing in this statement from beginning to end that you yourself put into this statement?

Miss MAGEE. No; except that before she wrote it we discussed our general ideas.

Senator DONNELL. But she prepared the statement and you did not prepare any of this statement?

Miss MAGEE. Except the revision of words here and there.

Senator DONNELL. Revision of words?

Miss MAGEE. That is right.

Senator DONNELL. And the words that you revised did not change the substance or the meaning?

Miss MAGEE. Not particularly; no.

Senator DONNELL. Not at all; did they?

Miss MAGEE. In some cases.

Senator DONNELL. Can you tell us one?

Miss MAGEE. I do not have the original draft here.

Senator DONNELL. How long since this was prepared?

Miss MAGEE. Last week. For instance, we had a different choice of language.

Senator DONNELL. Who prepared this language that—

> It is not my purpose to discredit the plan of S. 545 for assisting the medical needy as much as it is my desire to uncover the sterile thinking in which it was conceived.

Who prepared that?

Miss MAGEE. Mrs. Pilcher.

Senator DONNELL. Well, was there any particular importance attached to referring to the thinking behind this bill in which a good many people have cooperated and with respect to which the advice of many have been secured, as I understand it—is there any particular reason why you want to make a comment there that the thinking was sterile in which this bill was conceived?

Miss MAGEE. The rest of the paragraph explains that.

Senator DONNELL. It explains it? All right.

Now, as a matter of fact, you are not a doctor—you have said that.

Miss MAGEE. That is right.

Senator DONNELL. And Mrs. Pilcher is?

Miss MAGEE. She is not a practicing physican but she has finished in medicine.

Senator DONNELL. Ever practice medicine?

Miss MAGEE. Yes, sir.

Senator DONNELL. Where?

Miss MAGEE. Cleveland.

Senator DONNELL. How long did she practice?

Miss MAGEE. I would say probably 3 years. Or 1 year, on a hospital staff. And has several children.

Senator DONNELL. You are acquainted with the American Medical Association?

Miss MAGEE. Yes, sir.

Senator DONNELL. Do you know whether she belongs to it?

Miss MAGEE. I do not know.

Senator DONNELL. Do you know of the fact that the American Medical Association has been consulted and much thought has been put on this bill by representatives of the American Medical Association, an association which contains 120,000 or 130,000 of the physicians of the country? Did you know that?

Miss MAGEE. I did not know it, as a matter of fact. I had assumed they would be related to it.

Senator DONNELL. You think, however, notwithstanding, that this bill was conceived in sterile thinking; is that right?

Miss MAGEE. Well, I think I stand by the paragraph as a whole. I do not think by itself it is understandable.

Senator DONNELL. I can understand it all right. The sentence is complete; it has a subject, a predicate and very clear words, and you characterize, or Mrs. Pilcher does with your approval, the thinking behind this bill as sterile thinking in which the bill was conceived.

Well, I will not dwell on that further, but it occurs to me that perhaps it might be said in fairness to members of the medical profession and others who have cooperated that they probably have some thoughts that are worthy of consideration and not totally sterile.

Miss MAGEE. Yes, but they are not above criticism.

Senator DONNELL. Not at all, not in the slightest. I think it is perfectly proper for you to criticize but in one breath you say:

> It is not my purpose to discredit the plan of S. 545 for assisting the medical needy as much as it is my desire to uncover the sterile thinking in which it was conceived.

Miss Magee, let me ask you some questions. Have you studied the effect of compulsory health insurance in the various countries in which it has been tried out?

Miss MAGEE. I have not made an elaborate study. I have observed it somewhat in England.

Senator DONNELL. You have been in England?

Miss MAGEE. Yes.

Senator DONNELL. When were you there?

Miss MAGEE. In 1931.

Senator DONNELL. Sixteen years ago?

Miss MAGEE. That is right.

Senator DONNELL. How much study did you put in on it at that time while you were in England?

Miss MAGEE. I was primarily studying unemployment insurance that summer and it was somewhat on the side, but I want to go on to say I have read some books on it. I am not an expert in the field.

Senator DONNELL. In England when you were over there 16 years ago, did you consult with doctors or hospitals or the authorities in charge of them as to whether or not their plan had been successful?

Miss MAGEE. I talked mostly with social workers and to some extent with some of the people in the what they called friendly societies; but of course since that time it has been changed very much.

Senator DONNELL. And, as you say, you are not an expert on the subject.

Miss MAGEE. We do not try, in our testimony, to do anything except get at what seems to us the general philosophy back of it.

Senator DONNELL. And in fact, Miss Magee, when you get right down to it, this resolution adopted on January 18, 1947, does not tell us even whether by compulsory health insurance you mean insurance which provides cash payments or whether it is insurance that gives professional services.

Miss MAGEE. It is a general statement.

Senator DONNELL. Very general statement and does not tell which you mean, does it?

Miss MAGEE. It does not in the resolution.

Senator DONNELL. No. Well, that is the official document of your organization on that subject?

Miss MAGEE. The latest one.

Senator DONNELL. Is there any other document that your organization has issued that is any more specific than that?

Miss MAGEE. Resolutions were passed in other years; I do not have them in front of me, but I can make them available.

Senator DONNELL. Do you have a recollection as to any of them, any that more specifically outline whether you are talking about cash benefits of insurance or a plan under which the Government supervision is the administration of medical health and surgical services?

Miss MAGEE. No.

Senator DONNELL. You do not?

Miss MAGEE. No.

Senator DONNELL. Now, you said that meeting in New York City consisted of over 400 people or thereabouts, this year.

You were there, I suppose?

Miss MAGEE. Yes.

Senator DONNELL. Were those 400 from all over the United States?

Miss MAGEE. Mostly from Eastern States.

Senator DONNELL. Mostly from New York City, were they not?

Miss MAGEE. New York, New Jersey, Connecticut, and Massachusetts, Ohio, and Michigan.

Senator DONNELL. How many of them were from New York?

Miss MAGEE. The majority.

Senator DONNELL. The majority of the 400 were from New York and New Jersey. Were there any of them at all from Western States?

Miss MAGEE. I do not believe so.

Senator DONNELL. All right; Michigan. We will take Michigan. That is not quite the far West, I take it, but was there anybody there from west of the Mississippi River?

Miss MAGEE. I do not believe so. But I could not swear to that.

Senator DONNELL. Who drew these resolutions, if you know?

Miss MAGEE. A resolutions committee.

Senator DONNELL. A resolutions committee?

Miss MAGEE. Yes.

Senator DONNELL. Were you head of that committee?

Miss MAGEE. No.

Senator DONNELL. Do you know who was the head of it?

Miss MAGEE. Mrs. Thomas McAllister was the chairman; Mrs. Florence Kelly was the other member, if I remember rightly.

Senator DONNELL. Just two members?

Miss MAGEE. That is right.

Senator DONNELL. Now, is Mrs. Thomas McAllister a doctor?

Miss MAGEE. No.

Senator DONNELL. Is she expert on health insurance?

Miss MAGEE. I do not think so. She is chairman of the board of directors of the National Consumers League, Grand Rapids, Mich.

Senator DONNELL. Is she a professional, a homemaker, or what?

Miss MAGEE. Not a professional woman.

Senator DONNELL. Where does she live?

Miss MAGEE. Grand Rapids, Mich.

Senator DONNELL. And she lives there with her family, does she?

Miss MAGEE. Yes.

Senator DONNELL. And she, so far as you know, has not, has she, ever specialized along the line of economics or the medical features of health insurance?

Miss MAGEE. Not the medical features; I do not know about the economics. She is a very studious, well-educated person.

Senator DONNELL. You do not know her educational background at all, do you?

Miss MAGEE. She is a graduate of Bryn Mawr College.

Senator DONNELL. When?

Miss MAGEE. I do not know.

Senator DONNELL. Do you know whether she studied economics or not?

Miss MAGEE. I imagine she did because she knows a good deal about it.

Senator DONNELL. You do not know, as a matter of fact, what she studied at Bryn Mawr?

Miss MAGEE. No; I know she has a bachelor's degree from there and has done graduate work at the University of Michigan.

Senator DONNELL. You do not know whether she has made any special study of the history of compulsory health insurance, do you?

Miss MAGEE. I do not know whether she has. There is nothing technical in the resolution. It expresses general principles.

Senator DONNELL. You are renewing the support of compulsory health insurance and you are coming down here and testifying before a United States Senate subcommittee with a view to advising the Congress of the United States as to whether or not compulsory health insurance should be put into effect and it does seem to me, Miss Magee, that is a fair question to find out how many of the people who are drafting this kind of resolution know about the subject matter. Do you not think that is true?

Miss MAGEE. Dr. Hamilton was presiding at the meeting. If you wish for further——

Senator DONNELL. She presided at the meeting but was not on the resolutions committee, you said.

Miss MAGEE. No; she probably saw them ahead of time but was not a member of the committee.

Senator DONNELL. You do not know whether she did see them?

Miss MAGEE. I think so.

Senator DONNELL. Did you see her see them?

Miss MAGEE. I saw her the day before the meeting and I am quite sure.

Senator DONNELL. But this had been prepared before she saw them?

Miss MAGEE. That is right.

Senator DONNELL. Now, what was or is Mrs. Florence Kelly?

Miss MAGEE. Attorney.

Senator DONNELL. And where does she practice?

Miss MAGEE. In New York.

Senator DONNELL. And do you know whether or not she specialized in the study of health insurance?

Miss MAGEE. I do not know.

Senator DONNELL. Do you know anything about the cost, Miss Magee, of health insurance under the plans set forth in S. 1320?

Miss MAGEE. No.

Senator DONNELL. Have you read S. 1320?

Miss MAGEE. Yes, but I am not testifying on that.

I was not testifying on that. I did not offer any testimony along that line.

Senator DONNELL. And you do not undertake to say what the cost would be under that?

Miss MAGEE. No.

Senator DONNELL. Do you know what the experience has been in New Zealand?

Miss MAGEE. Only what you referred to this morning.

Senator DONNELL. Have you heard of anything to the contrary?

Miss MAGEE. I do not know anything more.

Senator DONNELL. And do you know whether or not there has been considerable controversy in England as to the question of the success or lack of success of compulsory health insurance?

Miss MAGEE. There was a great deal of controversy about it at the time they changed their plan.

Senator DONNELL. There was a great deal of controversy last year, was there not?

Miss MAGEE. At the time they changed from insurance to free medical care.

Senator DONNELL. Do you know anything about the administration of the English plan?

Miss MAGEE. At present?

Senator DONNELL. Yes.

Miss MAGEE. No.

Senator DONNELL. Lord Hewart of Bury, Lord Chief Justice of England, was guest of the American Bar Association some years ago and spoke. I would like to read a sentence or two from a work by him which was published in 1929, reading as follows:

> As to corruption, that is a vice from which the service is doubtless at present free, though, even so, there is no certainty that it will remain so, and, if there were any great extension of the system of giving uncontrolled and arbitrary powers to public officials, it is as certain as that night follows day that corruption must creep in. We shall then be cursed with the corrupt bureaucrat. The bureaucratic despot we already have. To take a simple instance, the treatment of the panel doctors under the National Health Insurance Acts is pure despotism. The doctors are liable, at the mere discretion of the official who acts for the Minister of Health, to be ruined professionally by being struck off the panel, or, as a lesser punishment, to be fined to an arbitrary extent.

Now, that was in 1929. You were in England in what year?

Miss MAGEE. At various times; the last time I was there was in 1931.

Senator DONNELL. Two years after Lord Chief Justice Hewart made these observations.

Do you know whether his observations are correct or incorrect?

Miss MAGEE. I have no basis for knowing.

Senator DONNELL. The paragraph proceeds as follows:

> In one instance, a fine of 1,000 pounds was imposed on two doctors who carried on business in partnership. Excessive prescribing, an offense wholly unknown to the law, which consists in prescribing for the patient medicines that are either too expensive in quality or too liberal in quantity, is one of the things for which a doctor may be penalized. One might think that, for a person who

> is bound by law to insure and pay contributions under the acts, the best medicine ought to be prescribed in illness. But apparently that is not the view of the department. One might also wonder whether, in this matter, the interests of the patients are taken into consideration at all.

Now, from your observations, the year you were there, 2 years after the Lord Chief Justice of England made these observations, are you able to state whether the general statements made by him that I have read are true or not?

Miss MAGEE. I would not be able to say.

Senator DONNELL. You did not make any detailed study?

Miss MAGEE. That is what I testified earlier.

Senator SMITH. I would like to ask you, Miss Magee, this question, because it has come out in the testimony here from others.

The plan of S. 1320 which compulsory health insurance—and as you say, you are not testifying on it but you favor that principle—contemplates, according to some witnesses, covering 90 percent of our population. According to various witnesses, the compulsory deduction from pay rolls and other means of that sort would raise from three to five billion dollars in the lowest estimates and much higher than that in other estimates; also it was brought out by a witness that the cost of over-all program based on the population that would be affected would be perhaps around eight or ten billion dollars.

Now, I do not suppose your organization has ever studied this question, whether, assuming we tax everybody, the Government is under obligation then to deliver something for the tax paid. I do not suppose you have studied how any practical means could be devised by the complete association of our medical practice to cover this responsibility.

Miss MAGEE. Is it not contemplated?

Senator SMITH. That is one of the practical questions of these things.

We are trying to see how the various objectives would be accomplished, how we can take care of people who cannot afford to pay.

I agree we have that responsibility. But I have not had any testimony from you or people who were members of your consumers' league to state how they can make it work.

Assume that a man is taxed through pay-roll deductions through the year, then has an illness and the services are not delivered. As the doctor says here, it would be a complete fraud. The attempt could not be organized within a generation.

Miss MAGEE. Is it not the same principle, Senator Smith, that we have in old-age survivors' insurance?

Senator SMITH. I do not think so at all. That is a matter of dollars and cents. A person might pay into the pot and get back from the pot social security or anything else. They receive the share they paid, but to get a service, to organize a service, is the big problem we are faced with here.

Miss MAGEE. But there are actuarial data on which such estimates could be made as, for instance, I had a good deal to do in early days with insurance in some of the States in working with the State commissioner of unemployment insurance.

Senator SMITH. That is a tax, not insurance, there. There is a difference between a tax and insurance. A person pays according to income from the pay roll. That is not insurance. That is a tax. The point is, how to give that person the same service as the person who pays on a pay-roll basis. The insurance is on the basis of what it costs on actuarial tables, what it costs to give the service. They are two totally different things. We are talking about tax, not insurance at all. The question of insurance is totally wrong. We are talking about compulsory health tax and it is quite legitimate to make criticisms of it, but we have that problem before us.

But I want your analysis of your organization that is made along the lines as to how you can make it work.

Miss MAGEE. I would still think that it was analagous as far as the risk is concerned to unemployment insurance, if you prefer that term, rather than insurance, and I started to say that in the beginning there we did not have as good actuarial data for unemployment as we certainly have for the cost of sickness because there were no records to show how many people suffered the risk of unemployment.

But there was a safety factor and over a period of years, as you know, it has been found possible to raise the benefits of unemployment compensation very materially because of the guess being on the safe side.

Now, I would say that we have, certainly, through various sources that would be available, data on which actuarially it would be possible to figure what the cost might be, and that the pay-roll tax could be adjusted to that. It is my assumption that pay-roll tax rather than general tax——

Senator SMITH. The medical profession would be put on the Federal or State pay roll, depending on how it worked out.

You would revolutionize our whole program of health service in this country. You would do that in one fell swoop. One plan like this would change the whole picture.

Now our theory—I regret that you call it sterile thinking because I happen to be one of the——

Senator DONNELL. We do not mind—I regret you think we should be.

Miss MAGEE. I apologize.

Senator DONNELL. Our theory is that the only way we can learn about this is to proceed step by step and see how it works, what people can afford to pay. You cannot make an over-all blueprint and tax everybody to put over the plan in this country. It just does not work that way.

Senator SMITH. And the only way to do is by a trial-and-error method, by trying to see what the States can do, as witnesses have said here constantly, and they approve this bill, S. 545, because it takes the thing step by step and not in one fell swoop.

Miss MAGEE. But it seems to us that the steps are not in the direction of self-support and payment through what seems to us an insurance plan would be; but it is taxation of all to pay for a certain group. I mean they are just different theories of taxation.

Senator SMITH. Well, you have not answered my question as to whether your league has made any study of insurance or how you arrived at——

Miss MAGEE. In the discussion of that committee I think it has been assumed all along that it would be a pay-roll tax similar to social security tax.

Senator SMITH. Social-Security benefits are something you receive in cash out of the pot; we will not discuss how those funds are handled.

Miss MAGEE. There is a risk there.

Senator SMITH. That is a very different matter. If you are going to say that we are going to have a tax here and give a person back out of amounts accumulated a certain amount under certain conditions—but you are not doing that; you are guaranteeing to give a service by this.

Miss MAGEE. But this old-age survivors' insurance; we guarantee to the children and to the widow of the worker who dies, and they get more, in many instances, than the worker did.

Senator SMITH. Guaranteed service or money?

Miss MAGEE. Money.

Seantor SMITH. There is all the difference in the world.

You are guaranteeing a service here and you are forcing the Government to go into the business of organizing that service. If you want to give people so much per head for medical care, that is an entirely different problem from what you are suggesting. What are your suggestions with reference to possibly putting the Government in the business of organizing this service and completely revolutionizing your medical service of this country, hospitalization and everything else?

Miss MAGEE. You are not asking me about it on a functioning basis but how to have enough doctors and hospitals?

Senator SMITH. You cannot separate them.

If you are talking about what you call compulsory health insurance, that is not what you are asking. If you want to set up a fund to tax everybody to put money into the pot and give that money out of the pot over in the same way as social security, that is another thing. You can do that. That can be done by just simply increasing the tax every year. But when you are undertaking to deliver service—and I want to emphasize that—you are in a different problem than we are dealing with in these hearings.

Miss MAGEE. You mean from the standpoint of the number of physicians and their locations?

Senator SMITH. The whole business.

How are you going to give a full medical coverage to everybody, the whole 140,000,000?

Miss MAGEE. I would say one first step in the direction of that was the Hill-Burton bill which simply is to provide facilities.

Senator SMITH. We passed that bill last year in the nature of grants-in-aid, experimentally. We would not dare to do it any other way.

Miss MAGEE. But the first step is to provide physicians. The other problem would be certainly helped by the contemplated grants to medical schools and for making more physicians available. I am sorry that I did not catch the import of your question when you first asked me.

Senator DONNELL. I am afraid you are still not giving Senator Smith's question the full import it contains. He is not talking about statistics, of how many doctors there are going to be; he is pointing out that this involves a governmental insurance plan, the Government organizing a great mass of doctors and prescribing regulations and rules and determining who shall be used and when they can be used and who are experts and who are not experts. It is an entirely different thing from the operation of a statistical business when you collect so much and pay out so much in dollars. That is what your question is, is it not, Senator?

Senator SMITH. Exactly, and your resolution here does not tell us at all whether that is the thing you are talking about or whether what you are talking about is merely the statistical business. You do not tell us in your resolution whether you are in favor of entering into a medical scheme under which hospital services and medical services and surgical services are to be provided or whether you are just going to provide insurance like you buy from the Metropolitan Life Insurance Co.

Now, which is it you are advocating?

Miss MAGEE. Well, of course you are getting into rather technical aspects.

Senator SMITH. We are not getting technical. It is the same issue before us.

Senator DONNELL. Are you advocating a plan when you talk about compulsory health insurance in your resolution and in your testimony? Are you talking about a plan where the Government will raise some money by taxation and then set up a fund and out of that fund pay out in cash indemnities to people who are sick?

Miss MAGEE. No; I do not think that is what is contemplated.

Senator DONNELL. You are in favor of the plan in S. 1320?

Miss MAGEE. Approximately that.

Senator DONNELL. Are you in favor of that bill?

Miss MAGEE. That is right.

Senator DONNELL. Have you read that bill?

Miss MAGEE. I have.

Senator DONNELL. Well, now, while we are talking about that bill, you made quite a point here and somebody uses quite a little language here to this effect:

> The eligibility of those who would benefit from S. 545 must be proven by means test. You have undoubtedly heard the vigorous outcries against this—its humiliating effects—the bitterness it would breed. Shall it be said of the only great country to emerge from this world conflict, richer in national income and in productive capacity, that it sought to remedy the condition of its least fortunate by treating their bodies while it broke their hearts?

That is from your statement or the statement Mrs. Pilcher prepared and you looked over and made thereon any corrections that you wanted to. Now, are you familiar with the fact that in S. 1320, section 205 (A), there is a distinct provision saying, "Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor, for any period for which equitable reimbursements to the account on behalf of such needy or other individuals have been made, or for which reasonable assurance of such reimbursement has been given, by public agencies of the United States, the several States, or any of them or of their political subdivisions, such reimbursements to be in accordance with agreements and working arrangements negotiated with such public agencies. Services furnished to such needy or other individuals as benefits shall be of the same quality, be furnished by the same methods and be paid for through the same arrangements, as services furnished to individuals eligible for benefits under this title."

Do you not realize, Miss Magee, that that involves in itself—in order that the public agencies may determine how much money they are going to pay—that that involves in itself a means test; otherwise, how are you going to tell who is needy and who is not?

That is in S. 1320, the Murray-Wagner-Pepper-Chavez-Taylor-McGrath bill. That is in there, is it not?

Miss MAGEE. It is in there but I understand it is quite different because these are people who are not at work and therefore are not covered. That is not the same thing as is implicit in the powers of the State agency under S. 545, where it would seem to me would be more involved in a means test.

Senator DONNELL. By the word "needy" as used in section 205 (A) of S. 1320, obviously it is contemplated that somebody is going to find out whether they are needy.

Miss MAGEE. Probably people under the care of an agency.

Senator DONNELL. I say, that involves the determination by some kind of test whether those people are or are not in need.

Miss MAGEE. That is right.

Senator DONNELL. While talking about such eloquent things as breaking people's hearts on this means test, section 205 (A) of the Wagner-Murray bill itself provides for a means test as to those particular individuals covered by that section? That is true, is it not? Is that true?

Miss MAGEE. I will have to refresh my mind.

Senator DONNELL. You will find it on page 13.

Miss MAGEE. Yes, but as I get the sense of this paragraph, it means these people are already under the care of public agencies, public relief agencies, who would not be taken on unless there were a means test. Now, they have been taken on to provide the needs of life, the necessities, maybe housing, food, clothing; they are the clients, let us say, of that agency, and the arrangements made that this agency pay into the fund for them, because they are not employed and they would not have it taken from a pay-roll tax. That, to me, is a different conception. I may be wrong in the interpretation. But I have the conception that all of the money under S. 545 has to be on the basis of need.

Senator DONNELL. I am not saying, Miss Magee, that the two bills are identical in that respect at all. The point is that I am emphasizing that there is a provision in section 205 (A) whis is headed with this language, "Provision of benefits for noninsured needy and other individuals." That is section 205 (A) which contains the language which I read, and also has this further sentence which provides that services furnished to such needy or other individuals as benefits shall be of the same quality, be furnished by the same methods, and be paid for through the same arrangements, as services furnished to individuals eligible for benefits under this title.

And the point I make is that somebody is going to have to determine whether or not the people that are being talked about in that section 205 (A) are or are not needy and the only way you can find out is through a means test.

Miss MAGEE. That is right, and we have recognized the validity of that in the general giving of relief.

Our objection is to it as spreading into this basis for giving of health services.

Senator DONNELL. That is to say, you are objecting to spreading it as widespread as you think it is by S. 545, but the same identical point, the means test, is to a limited extent in section 205(A) of S. 1320.

Miss MAGEE. That is right.

Senator DONNELL. I think that is all. We thank you very much for your testimony.

Now, the next witness is Mr. William Galvin, New York State Federation of Labor.

Mr. GALVIN. Mr. Chairman, for reasons of time I would like to permit Mr. Weyler of the Kentucky State Federation of Labor to precede me.

Senator DONNELL. Very well, we will hear from Mr. Weyler.

I am advised that Mrs. Louis Ottenberg of the National Council of Jewish Women has telephoned that she will not appear because of illness. Her statement has been filed and it is hereby directed to be placed in the record of these proceedings at this point.

(Mrs. Ottenberg's brief is as follows:)

STATEMENT OF MRS. LOUIS OTTENBERG, NATIONAL COUNCIL OF JEWISH WOMEN, INC., NEW YORK 23, N. Y., AT HEARINGS ON S. 545, BEFORE HEALTH SUBCOMMITTEE OF SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

The National Council of Jewish Women, with a membership of 65,000 in chapters throughout the United States, derives its authority for expressing its views on a variety of public issues from resolutions adopted at national conventions held by the organization every 3 years. The subject of medical care and national health insurance has been studied by the membership of the organization for a number of years. The educational material distributed to the membership contained information derived from sources opposing and supporting a national health insurance program. Resolutions for the support of a health insurance program have been submitted at three of our national conventions, and twice these resolutions have been referred for further study. This is evidence that a great deal of consideration has been given to the resolution adopted at our last triennial convention held in November 1946, and quoted below:

"Whereas existing medical facilities and services are insufficient to cope with America's health needs; and

"Whereas medical expenses cannot be budgeted or anticipated, and many families are unable to pay for the medical assistance they require; and

"Whereas disability and death could often be prevented if the full benefits of existing medical facilities and medical services were available to all people regardless of costs; and

"Whereas existing health insurance plans in the United States have demonstrated the practicability of the insurance principle applied to sickness, but have also shown the inability of the voluntary plans to reach more than a fraction of the population who need coverage: Therefore be it

"*Resolved*, That the National Council of Jewish Women endorse the extension of programs for preventive medicine, and the development and extension of Federal, State, and local health facilities; be it further

"*Resolved*, That the National Council of Jewish Women endorse the principle of national health insurance."

In view of this action taken by the organization, I am appearing before your committee in opposition to the National Health Act of 1947, S. 545, because the bill proposes to solve the national health problem by offering medical charity. A major part of our organization's program is the rendering of social services by its members in communities throughout the United States, and our experience has shown that charitable assistance is accepted by most people with great reluctance, and only when the need is extreme and the condition is of an emergency nature. It has always been our philosophy that people must be helped to help themselves, rather than to perpetuate a condition where the need is always to be met by charitable assistance.

Under this bill, each State, or its subdivisions, will determine who is entitled to receive assistance, and may use its own method to determine eligibility. Thus, in order to receive aid to cover medical expenses, low-income groups will be subject to classification according to income, to a means test, or they will be forced to take a pauper's oath. This is a step backward to the days when the poor were humbled by the patronizing contributions of charity, and contrary to the philosophy of social responsibility. Also, by providing that school children will be classified according to their families' incomes, and only the neediest chosen to receive medical aid, the bill emphasizes economic and class differences among the children, thereby creating an atmosphere not conducive to the promotion of democratic ideals.

According to an American Medical Association report issued in 1940, most individuals and families with incomes under $3,000 required help in meeting expenses for medical care. It is estimated that this group in 1946 constituted 97,000,000 Americans, or 69 percent of our population. Since the sponsors of this bill themselves state that S. 545 is designed to aid about 20 percent of our population, it is fair to conclude that this program will not meet the challenging national medical problem. One of the primary objectives of a sound and comprehensive national health program is the development of a healthy population. Preventive services and early diagnosis are therefore essential. And since, as we have pointed out before, people are reluctant to accept charitable aid, and do so only in emergencies, medical charity is totally inadequate for the promotion of good health.

On January 6, 1947, the President, in his message on the state of the Union, stated, "Of all our national resources, none is of more basic value than the health of our people." The President's Advisory Commission on Universal Training, in its recent report, stated, "A strong united Nation is our No. 1 security requirement." Among the important means of achieving this security, the Commission listed improved physical and mental health. These statements, against a background of information that 40 percent of young Americans were unfit for military services for medical reasons, and that before the war between four and five hundred million work days were lost annually from sickness, emphasizes the need for a broad and comprehensive national health program. We feel that this program can be best carried out through a system of national health insurance which establishes the right of every American to adequate medical care, regardless of his immediate economic status. Insurance to care for long-range need and emergencies is an accepted American principle. A program of national health insurance is a logical extension of this policy. We have already provided for the risks of unemployment, old age, and death. Sickness remains a threat to security for which there has been no over-all planning. A system of health insurance will provide the opportunity for every American to secure the medical care he requires in a dignified and self-respecting manner. We respectfully urge this committee to reject S. 545, and give serious consideration to the adoption of a national health insurance program.

STATEMENT OF EDWARD H. WEYLER, SECRETARY-TREASURER, KENTUCKY STATE FEDERATION OF LABOR

Senator Donnell. Mr. Weyler, how large an organization is the Kentucky State Federation of Labor for which you appear?

Mr. Weyler. Approximately 165,000 members. It fluctuates from month to month, but it usually averages 165,000.

Senator Donnell. Has the giving of this statement today by you been authorized by any committee or convention of the Kentucky State Federation of Labor?

Mr. Weyler. Authorized by the executive board and drawn jointly by myself and our department of education and research.

Senator Donnell. What is the name of the person or persons who collaborated?

Mr. Weyler. A couple of directors of the department, Mr. Duvall and Mr. Wolf.

Senator DONNELL. Very well, when did your committee authorize the making of this statement, or was it by resolution that it was so authorized to be done?

Mr. WEYLER. Not by resolution; by suggestions and motion.

Senator DONNELL. How large an attendance was present at the time the action was taken?

Mr. WEYLER. The executive board members.

Senator DONNELL. Approximately how many?

Mr. WEYLER. Altogether, 11 board members.

Senator DONNELL. From all parts of the State?

Mr. WEYLER. Yes, sir.

Senator DONNELL. All right; you may proceed, Mr. Weyler.

Mr. WEYLER. I would like to offer corrections to the brief that I have filed in the reading and discussion of the bill. We had assumed by the figure 66⅔ on page 21 and 33⅓ on page 29, that that prompted our statement on page 5 of my brief, under opposition to S. 545. The first sentence in the first paragraph which now reads "two-thirds of the cost of the program must be borne by the States, one-third paid by the Federal Government" I would like to correct that to read as follows: "The bill requires that States have to put up an amount equal to the Federal contribution, but it also says that States may count in money they are now spending for similar purposes."

This means that the wealthy States will not have to put up any new money, only poor States like Kentucky, those least able to pay will be taxed in order to get the benefits.

Senator DONNELL. From what portions of S. 545 do you derive that conclusion, Mr. Weyler?

Mr. WEYLER. I derived that conclusion from talking with numerous other people since I have been here and——

Senator DONNELL. What is in the bill that authorizes that conclusion?

Mr. WEYLER. If you will give me time, I will try to find that in the bill.

(Short pause.)

It is part of the bill where it says, the unused portion can be used from one cost to another cost.

You know the bill by heart, perhaps.

Senator DONNELL. I do not know it by heart but I would like to have you tell us from what it is that you draw that conclusion so we may have the benefit of that information when we are considering your testimony.

Mr. WEYLER. On page 18 it says:

> Such program may, at the option of the State, provide medical-care services in one or more of the following ways: In institutions, in the home, or in physicians' offices. Such program may also provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State, to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor.

There are numerous States which, we believe, are doing a great part of that particular thing at the present time and inasmuch as they are expending the particular parts of money they are for those things at the present time, that could be used as a part of the fund-matching program, whereas in the State of Kentucky where we may not, it would be necessary that we come up with a proposition to match such moneys as we would receive from the Federal Government.

Senator DONNELL. I do not know yet what is the particular language in this bill on which you base the conclusion that you have set forth.

I understand you to state it is on this page 18. We will not take much longer on this unless you desire to take longer.

Mr. WEYLER. No, I do not. It is line 13 and the following on page 18.

Senator DONNELL. Is that where you derive that conclusion? That is where you read from.

Mr. WEYLER. Then go over on page 19, line 17:

> The financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the amount contributed for similar purposes in the year 1946.

Senator DONNELL. Contributed?

Mr. WEYLER. Contributed for similar purposes in the year 1946. That is the language on pages 18 and 19.

Senator DONNELL. Upon which you rely to make that conclusion?

Mr. WEYLER. Yes.

I would like to make another correction, sir, on page 6.

Senator DONNELL. I wanted to be sure you understand this, Mr. Weyler. You notice the language on page 19, lines 17, 18, and 19 reads:

> The financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the amount contributed for similar purposes in the year 1946.

You notice that.

Mr. WEYLER. Sure.

Senator DONNELL. Proceed.

Mr. WEYLER. On page 6 of my brief, under the line where it says the Kentucky State Federation endorses—supports is the word that should be there and I would like to insert the word "supports."

Senator DONNELL. That is inserted.

Mr. WEYLER. Now, Mr. Chairman, we have tried to be intelligent in our remarks in favor of one bill and in our opposition to another one and we have tried to secure facts to present to you and I am sure that you appreciate facts.

At the time of the drafting of the brief, we had not yet received all the facts we had asked for and I received by letter two affidavits from Mr. Abe Vales who is the president of the United Mine Workers, the district at Middlesboro, Ky., in which he says:

> I was out of the office when this letter arrived and I have had to hurriedly assemble some statements that I hope may be helpful to you when you appear before the Senate subcommittee.
>
> Sorry I did not have time to do better jobs but certainly doctors and hospitalization in this part of Kentucky are deplorable and need correction.
>
> I would like to see the Senate subcommittee visit our district and make personal investigation of the doctors and the conditions of the hospitals.

Now, I had prepared 75 copies of the two attachments, A and B, which I have left with the secretary of the committee. He has them and if you do not mind, I would like to read those into the record.

Senator DONNELL. Read them in or have them filed?

Mr. WEYLER. Read them, because of the contents.

Senator DONNELL. All right.

Mr. WEYLER. This is headed "The need of better medical care for the coal miners of Kentucky."

In the coal fields of Kentucky we have prepaid medical care. However, the individual has little or no discretion in selecting their physician. Under the national health insurance and public-health bill, S. 1320, the individual would have a free choice of his doctor or hospital.

The case of not being able to select one's own doctor is illustrated in most of the coal-mining communities as there is usually only one doctor living there.

Even after a doctor has been selected it is not a guarantee that the miners and their families will receive treatment as most of the doctor's contracts exclude more than the include.

A specialist is rarely found in the coal-mining area. Usually the patient is required to travel from 150 to 200 miles to one of the larger cities before he can secure this service.

Management exerts considerable influence upon the selection of physicians by withholding company-owned office space, living quarters, etc., from the physician whose selection is not approved by the operator.

In several instances, and particularly in Harlan County, many of the doctors are large stockholders in either the coal mines or in the land companies which are leased by the coal companies. One doctor who receives more than $1,500 pay-roll deductions from employees of several mining towns owns and operates three coal mines. One can readily visualize this doctor testifying against himself in a compensation hearing.

Only recently in our district two doctors formed a corporation with two other businessmen, purchased and operate a mine from the War Assets Administration. Surely they would not testify against themselves in a compensation hearing when some miner has been injured or killed because they refuse to make their mines safe.

When a doctor is found to be incompetent and the employees, for various reasons, decide they no longer want his services, he is petitioned out. However, when these employees go to the county medical association and ask for another doctor, the association refuses and sends the same doctor back to them. It is practically impossible for a new doctor to come into the territory unless he has the blessings of the county medical association.

The other day a man came to my office who had gotten a pick stuck through his foot. He was given a return-to-work order by the doctor, not his own personal doctor, but one selected by the coal company. This man's foot was so swollen he could not wear his shoe. Is this the type of medical care a man deserves after working some 30 years in the coal mine?

Another instance is the one of a coal miner who remained home to care for a sick child and his wife who gave birth to a baby. The doctor and nurse delivered the child, but did not visit the mother again for 10 days even though the man had called them several times. This man testified before the joint board of arbitration, to use his words, "My wife had nearly mortified and stunk so we could hardly stay in the house." The reason for this man appearing before the arbitration board was that he was trying to get his job back. The company had discharged him for being absent from work 2 days without permission from the management, although the doctor had promised that he would report to the management for him, but failed to do so.

The need is great and Congress should recognize the opportunity to give the citizens a chance to receive proper medical care. The need for more and better hospitals in the mining areas is appalling. The majority are ill kept and filthy, and are staffed by inefficient help.

The people of Kentucky are reluctant to accept medical services on a charity basis. In some instances men who have lost a limb have refused to accept the aid of the State vocational and rehabilitation office. Therefore, we feel that in order to insure proper medical care it is necessary for Congress to enact the National Health Insurance Act (S. 1320).

The foregoing was signed by Abe Vales, president, district 19, United Mine Workers of America, Middlesboro, Ky., June 23, 1947.

Now, Mr. Chairman, in this bill, as we understand it, we would appoint, or we would have an agency, and this agency would have an administrator. This administrator must be a doctor of medicine licensed to practice, which means that he is a member of the American Medical Association.

Now, we do not know anything about the AMA because we live in Kentucky only. But if the policy and practice of the AMA is like it is down in Kentucky, we do not want a bureaucracy of AMA as a Federal agency in this country, and we are opposed to this provision, and we say further, Mr. Chairman, that you can go through this country and look in as many hospitals as you please and they are not headed by doctors. Business people are trained to administer; doctors do not know how to administer and they do not make good administrators, and we certainly do not want an agency set up where it is controlled, not only as to the administrator himself but as to members of the board, by an organization whose members can be or may be as arrogant as these statements prove doctors are down in Kentucky.

Now, that is one of the big reasons why we are opposed to this bill. We think an agency of this kind should be set up by practical people who have had years of training and experience in social service and welfare work. If it is going to be the policy of our Nation to do this sort of thing, then let us take people who are sympathetic with it. Let us not take people who are on record in opposition to it.

True, AMA may like this particular bill, S. 545; perhaps they wrote it; I do not know. But we of labor do not like it because of other provisions in it of which we do not approve, as I have outlined it in my previous brief, and because of provisions in other bills that we would prefer.

Now, I want to say, Mr. Chairman, that I never try to impose my own personal opinion upon men of such great intellectual ability as yourselves, being but a common layman from so far down in the sticks, but in my sticks we have supported our testimony, facts found by eminently qualified people.

Now, respecting this committee for Kentucky, for which I am treasurer, you have for officers such men as E. M. Josey, secretary of the Kentucky Pharmaceutical Association; the committees has Joe Betts, who is director of information of the Kentucky Farm Bureau. It has Fred Willkie, who is vice president of the Joseph Seagrams & Sons; Harry Schacter, president of the Ross Co.—84 organizations from all walks of life, and labor is only 1 of the 84.

They are eminently qualified. Phil Blackford, who is State commissioner, made the study and drafted this report upon which I have based my remarks to you.

I want to read you what he says in the back of this. He sums up by saying:

> Adequate medical care is not available to all Kentuckians. An important cause is the fact that personnel and facilities for medical care are inadequately distributed throughout the State. In counties with cities of first and second class, there are only 650 persons per doctor, while in rural areas there are more than 2,300 persons per doctor.

Down in the next paragraph is the answer. Professional personnel and facilities for medical care tend to be distributed in accordance with ability to pay rather than according to medical needs.

Mr. Chairman, I like the old-time doctor, the one who came and sat by your bedside and administered the medicine to the child and listened sympathetically while the child lived or died. I do not care so much about the modern doctor who in my opinion must be the type we refer to in this affidavit who thinks first of whether you have the dough to pay him and if you do not have it, he does not come and we know that that is true. I have had the experience, Mr. Chairman.

I have been married 24 years and in that length of time I have spent approximately $18,000 for doctors and hospitals and medicine. I know what it is not to have the money to have an abscessed tooth pulled—back in the depression when, if you do not have the buck in your hand, you do not get the tooth pulled.

Now, we are saying as a Government that we want to provide for our people, health standards and health assistance. Let us be practical about this thing; we can reduce the cost of health so that more people can afford it and so that the horrible conditions that the book sets out as exist in Kentucky will not exist, when people as this report shows here, thus, in Kentucky with first- and second-class cities where the annual purchasing power is approximately $900 per person, there is 1 doctor to 650 persons; whereas in rural areas where there is an average of only $200 per person, and only 1 doctor to each 2,300 persons.

Now, Mr. Chairman, doctors would go in business, perhaps, if they were not curbed out as is shown here [indicating] where you must have the blessing of the county medical association if you practice or do not practice.

Now, I think the medical profession has been profitable in practically every city in the country where you find the doctor living in the largest house and driving the finest automobile. So it must not be an occupation of poverty. Then there must be some reason why we do not have more doctors or why they are not in these areas. Are they not here because the associations will not permit? I do not profess to know the answer. But I think that your committee ought to make a personal investigation of this situation down in Kentucky and I think if you find it to be true, you ought to call upon AMA naturally, just as you do the American Federation of Labor and say to them, "If you are not responsible, we will pass laws to make you responsible," as you did to labor.

Justice should be rendered where justice is deserving and if we create a government to do for us such things as we cannot or will not do for ourselves, of our own free will, then I think it is called for.

Now, then, I heard you ask numerous people if they have believed in compulsory health. I think you will agree with me that the law that "thou shalt not kill" is a compulsory law. What is the difference, Mr. Chairman, if you kill me with a gun or if you give me tuberculosis and I die from that cause? If it is a sin to shoot you, why is it not a sin to infect you with venereal disease? Certainly, it should be compulsory, but when it is compulsory we should have a card in the pocket saying we are entitled to certain benefits and privileges and because we paid our portion, and go in and get it. Then we are not accepting charity and people in Kentucky, as in Virginia, are proud and do not like to be subjects of charity.

Now, if I may go further, there are one or two other things I would like to comment on further, if I have the time, and I do not want to transgress too much upon your patience.

On page 9, lines 13 through 20, it says:

> The Director of the Office of Medical and Hospital Care Services shall be a doctor of medicine licensed to practice medicine in one or more States, who has had at least 5 years of active medical practice and who is outstanding in the field of medicine. The Director of the Office of Dental Care Services shall be a doctor of dental surgery who has had at least 10 years of active practice and who is outstanding in the field of dentistry.

Again, going back to the AMA, I would like to say that hospitals and institutions are not run by doctors. They are run by people trained as administrators, and let us not make this AMA a bureaucracy.

We support the cancer fund in Kentucky to the extent that just a few days ago because of the efforts of labor, they went over the top in the goal that they had set for cancer research. But we wonder why we only mention a specific figure for cancer and we do not mention it for others. Tuberculosis is just as deadly, the same as numerous others of our diseases.

Senator DONNELL. You mentioned that was an affidavit. It is not sworn to?

Mr. WEYLER. It is signed. This affidavit is signed by the committees from different unions.

Senator DONNELL. I am not questioning the truthfulness.

Mr. WEYLER. Well, call it a statement.

Senator DONNELL. That is what we should call it.

Mr. WEYLER. I think you know, knowing conditions as I do—you know that when we sign our names to something it is just as true as if sworn to.

Senator DONNELL. I am not questioning the truthfulness of it. But I do question the accuracy of their being described as affidavits when they are not.

Mr. WEYLER. I yield to the correction.

Senator DONNELL. All right, sir; very well.

Mr. WEYLER. Attachment B is the Doctor's Report, United Mine Workers of America, local union No. 6659 and local union No. 4493, Black Mountain Corp., Kenvir, Ky., a joint report of both local unions of mine No. 30 and mine No. 31 of the Black Mountain Corp., Kenvir, Ky., February 22, 1947.

I will read attachment B:

After reading this report, then I would like to refer to the bill as to our main objections and our fears. It is not so much objection, perhaps, as it is fear that we may not get justice and this is verified so much as to why.

> On November 12, 1946, Dr. R. S. Howard gave us a contract, which was different to our doctors' contract. This new contract was put out by the Harlan County Medical Association.
>
> Dr. Howard told us we would have to accept this new contract, or we would be without a doctor. The above local unions voted not to accept that new contract. On or about December 11, 1946, Dr. R. S. Howard gave us another new contract, which he said would go into effect January 1, 1947, which he told us, and the local unions, was about the same contract he had already. The local unions again voted not to accept that contract.
>
> Then, on or about December 22, 1946, the doctors' committee, of both local unions, which consisted of three men from each local union, began to try to locate and hire a doctor. This committee went to Knoxville, Tenn., Oak Ridge, Tenn., and LaFollette. This committee spent about two days on this trip talking to doctors and interviewing them for the purpose of hiring them as our doctors.

Several of the doctors we interviewed told us they would gladly take the job and were anxious for it, but said they were afraid to accept, because they were afraid the Harlan County Medical Association would fight them and put them out of it, and that the County Medical Association was behind Doctor Howard in his fight to stay at Kenvir; that if a doctor was dropped from the County Medical Association, or refused admission to it, it would injure them in their profession, and since no doctor could afford to fight their local medical association and to be in good standing they would have to go along with the policy of the county medical association, even if the policy was wrong. For the doctors, for their own protection, always hung together.

After we made the trips to Tennessee, we went to Lynch, Ky., where the United States Coal & Coke Co.'s mine is, and saw and talked to one doctor, Pelzer, the chief surgeon there. He told us about the same things the other doctors told us. We then contacted Doctor Hampton, surgeon, at the Harlan Hospital, and he then said he would accept the job, if the men wanted him. An election was held at Kenvir, according to the provisions of our contract, and Doctor Hampton was elected as the doctor over Dr. R. S. Howard, who ran against him. Doctor Hampton, in this election, beat Dr. Howard, even though the officials, or some of the Black Mountain officials, took an active interest to elect Dr. Howard. After this election, Dr. Hampton stayed with us for about 5 days, and then left without giving us any notice. We later contacted him on the telephone, and he said the reason he left was that there were notes left in his car, and in his room, telling him that Kenvir would not be a very healthy place for him to stay, and that he left because he was afraid of his life, or that he would get hurt if he stayed there. All this time, Doctor Howard, the defeated in this election, refused to leave and stayed in Kenvir, Ky.

Again we started to look for another doctor, and finally contacted one, Dr. Andelman, and also Dr. W. P. Cawood, and Dr. M. E. Howard .

Dr. Andelman was employed by the Harlan Hospital, which is operated by Dr. M. E. Howard and Dr. W. P. Cawood. Dr. R. S. Howard is a relative of Dr. M. E. Howard. Dr. Cawood, Dr. M. E. Howard, and Dr. Andelman told us, in very clear terms, that the only way we could secure a doctor was to cooperate with the Harlan County Medical Association, and we would have to get a doctor through the county medical association.

Dr. Andelman finally said he would accept the job, along with Dr. R. S. Howard, with the understanding that Dr. R. S. Howard was to resign within 30 days. Dr. W. P. Cawood and Dr. M. E. Howard also told us that if we would let Dr. Howard come back here it would put him in the clear with the county medical association, and also with the local union of the United Mine Workers of America here in Harlan County.

In order to secure a doctor, we, much against our will, had to meet the terms of these doctors as above mentioned. And, in accordance with what the above doctors told us, we finally secured the services of Dr. Andelman, along with Dr. R. S. Howard, who has agreed to resign in 30 days.

We are making this report merely to show the true situation, in our local unions, regarding the employing of a doctor. While it appears that we have a free choice in the selection of our doctors, this is purely fiction. And, in fact, that while we pay for this doctor, we have no free choice in this matter. We have been trying to secure a doctor free of any influence from the company and the county medical association, but now find that this is impossible.

We make this report hoping that some time we employees, who pay for the services of a doctor, shall have the right and privilege of electing a doctor without any outside interference.

It is signed:

Respectfully submitted, this the 22d day of February 1947. Under "Doctors' Committee, local union No. 6659," appears the signature of George Thomas, Charles Jackson, Sherman Sizemore. Under "Doctors' Committee, local union No. 4493," appears the signature of James Carpenter, Ike Murray, Martin Cormack. Both local unions are local unions of Black Mountain Corp., Kenvir, Ky.

Senator DONNELL. Do you oppose the inclusion of cancer or advocate the exclusion of other diseases?

Mr. WEYLER. We do not oppose the inclusion but it would be well, we think, if we would include all the rest of the diseases that we have with specific amounts so that people interested in those particular fields of endeavor know what they have to work with and really go all out and do a good job.

On page 14, when we talk of this low-income group——

Senator DONNELL. Mr. Weyler, are you familiar with the provisions of Public Law 410 with regard to venereal disease and tuberculosis?

Mr. WEYLER. I must plead ignorance.

I am only familiar with the lack of benefits to provide enough tuberculosis sanatoriums and beds which are so sorely needed in Kentucky. Due to the fact, if I may call to your attention in my brief just to show how horrible our tuberculosis conditions are, Kentucky has a one-third high tubercular death rate in the State. Eighteen hundred Kentuckians died of it last year, and every year. Fourteen thousands have active infections. Three-fourths of the 14,000 cases are not isolated and they are constantly spreading the infection.

Now, I think it is just as important that we get large sums of money to help control this, the same as it is to help control cancer. I have seen people die with tuberculosis in my family, numbers of them. I have seen healthy people who become infected and within just a few years dry up to nothing but skin and bones; I have seen the suffering they go through. I know the scourge that it is and for that reason I would suggest that we set in similar types of provisions for others.

Now, on page 14, in the title "General Medical Service for Families and Individuals With Low Income," we do not define what low income is. I have heard you ask several people what their definition of that was.

Now, the law does not decide or does not say, I do not believe, where low ends and medium would be.

Now it is true that the law says that we shall have certain screening and we shall find out what people are entitled to or not entitled to; but Mr. Chairman, I might start out, in the case of illness, by being able to pay for my illness. I may even have a job and may not be in low income and my case is already perhaps decided upon but I can get unemployed and this illness can be long enough so I will have exhausted my total reserve; then we have got to, if we are practical and know how we do things, whoever this person is that decides these particular questions, we have got the same politics with that gentleman to get on the roll; or go to the precinct captain or to the State man or even Members of Congress.

If it is going to be for all the people, it should not have those complications in it or should not be any danger of it. We are to pay so much deduction from our wage at the source and we should be given a card that will say to us, "We are entitled to this because we paid for it."

So for that reason we object to that.

Now, I fear, Mr. Chairman, I am about to take too much of your time and with that I would end my testimony and yield to whatever questions you may ask in the hope I may have the intelligence to answer them for you.

Senator DONNELL. Mr. Weyler, you prepared a brief and made certain corrections in connection therewith. In addition to your testimony do you desire to file that brief?

Mr. WEYLER. Please, sir, if I may.

Senator DONNELL. You have already read into the record the two statements to which you referred.

Who are the gentlemen who assisted you in the preparation of this, do you recall? Duvall and Wolf?

Mr. WEYLER. Yes.

Senator DONNELL. What are those gentlemen?

Mr. WEYLER. Mr. Duvall is director of the department of education and research. I might say, Mr. Chairman——

Senator DONNELL. Of the Kentucky State Federation of Labor?

Mr. WEYLER. Yes, sir. I might say our State is the only one that has a department of education and research.

Senator DONNELL. You mean your union is the only one that has this department?

Mr. WEYLER. In the United States. And I am very glad you called that to my attention.

Mr. Wolf is assistant to Mr. Duvall.

Senator DONNELL. I am interested to note in the brief that the AMA as early as 1939 reported that families with incomes under $3,000 were unable to pay for adequate medical care. Do you know what that statement is to which reference is made?

Mr. WEYLER. That was a reference to material that we had read and were reading at the time that we compiled the brief and that material is in the office of the department of education and research.

Senator DONNELL. That material is a table that appears in document entitled "Factual Data, Medical Economics, revised, 1940," issued by the Bureau of Medical Economics, AMA, is it not?

Mr. WEYLER. Yes.

Senator DONNELL. We already have that in the record; I will not comment on it, but that is what you refer to when you make this statement about the AMA as you quoted?

Mr. WEYLER. That also points out this statistical information: 69 percent of our families had incomes of less than $3,000 annually and in accordance with the reports of the United States Department of Labor of the necessary earnings for decent standards of living, then 69 percent of our population, at least, would be in the low-paid brackets, because they have not earned enough to decently sustain an American standard of living.

Senator DONNELL. Senator Smith, do you have any questions?

Senator SMITH. No questions.

Senator DONNELL. Mr. Reporter, if we have not previously stated at what point Mr. Weyler's prepared statement should be inserted in the record, it should go in here.

(Mr. Weyler's brief is as follows:)

BRIEF ON NATIONAL HEALTH INSURANCE PRESENTED BY EDWARD H. WEYLER, SECRETARY-TREASURER, KENTUCKY STATE FEDERATION OF LABOR

The need for public-health insurance in some form has long been established in the minds of the citizens of the United States. This need has been brought to the attention of Congress many times over, resulting in national and State laws which provide some remedial social benefits to our people.

Throughout the years groups of individuals have interested themselves in the plight of the average citizen and have used their influence and prestige in his behalf. It is interesting to note that the American Medical Association as early as 1939 reported that families with incomes under $3,000 were unable to pay for adequate medical care. This statistical information is documented and startling when, even as late as 1945, 69 percent of our families had incomes of less than $3,000 annually. The American Medical Association realizes the importance of prepaid health insurance and has pushed a program of voluntary participation but is not willing to advocate a national program.

Statistical information coming to light during the war years added emphasis to the need for national health insurance. For instance, the Army and Navy revealed that 40 percent of our boys and girls who registered for the draft had to be turned down as unfit for military duty. Many of these defects could have been remedied or prevented if adequate medical care had been available or could have been paid for during childhood.

Much of the illness which contributed to our high rate of absenteeism during the war could have been eliminated with proper medical care.

The Children's Bureau stated that in 1943, 31,000 babies and 3,000 mothers could have been saved with adequate medical care.

Forty percent of our counties do not have a recognized hospital. In 1944, 553 counties had less than 1 doctor per 3,000 population, which is considered the minimum requirement.

KENTUCKY'S NEED

The people of Kentucky are poor and desperately need help to obtain only the barest minimum health standards. We are not so fortunate as some of our sister States who have large industrial incomes to draw from. The average per capita income in Kentucky is $308, the fifth lowest in the country. The advantages to be derived from a real national health-insurance plan would be of great service to Kentucky.

The Committee for Kentucky, an organization made up of civic leaders, industrial, labor, and agricultural groups, and devoted to the principle of improving Kentucky and informing the citizens of the ills of our State, recently compiled and published a Report on Health. The statistics relative to the report were compiled by Dr. Philip E. Blackerby, State health commissioner, who has studied the health problems of our State for many years and is eminently qualified. The report is so startling that even many of our citizens found it hard to believe. Here are a few of the facts:

Tuberculosis.—Kentucky has the third highest tuberculosis death rate in the country. About 1,800 Kentuckians die each year from this disease. Some 14,000 have active infections * * * 50 percent above national average. Three-fourths of the 14,000 cases are not isolated and are therefore constantly spreading the infection. The reasons being (1) there are only 800 beds in Kentucky for tuberculosis patients and less than 200 are available to more than two million citizens, (2) 5,500 cases are not even known by health officers, (3) there are few adequately staffed clinics.

Sanitation.—Filth-borne diseases kill 800 Kentuckians each year. Only five States have more deaths than Kentucky from typhoid fever. Our death rate from dysentery is twice the rate for the Nation as a whole.

Three hundred and thirty-three communities have no public water supply. Two-thirds of our schools do not have safe water. One-half the State's population is served by open privies. Two-thirds of the total milk supply is not pasteurized.

Cancer.—One out of every 300 Kentuckians has cancer; 2,500 die each year from this disease, which ranks third in the leading causes of death. Many cases can be cured if found early and receive prompt attention. "But," says Dr. Blackerby, "the diagnosis and treatment of cancer require highly specialized techniques, which may be prohibitively expensive for a considerable number of victims." There are no homes for incurable cancer cases in Kentucky.

Mental health.—Seven thousand persons are being cared for daily in our mental hospitals. Mental-hygiene assistance is not available to most Kentuckians. One-ninth of our young men were rejected in World War II for mental illness and deficiency. Our mental hospitals are all overcrowded. Kentucky has been able to meet only 25 percent of its responsibility toward mental cases.

Venereal diseases.—About 100,000 Kentuckians have syphilis. One out of eight mental cases are due to syphilis. About 50,000 Kentuckians contract gonorrhea annually.

Diseases of later life.—It is significant that two-fifths of all deaths are due to heart diseases, cerebral hemorrhage, and nephritis.

Dr. Blackerby says: "These handicaps may be found through periodic health examinations. Few Kentuckians receive such examinations."

Dental health.—Seven out of 10 school children need dental care. There are too few dentists, especially in the rural areas where there is 1 dentist per 6,400 persons.

Industrial health.—The average industrial worker loses 7 to 10 working days per year due to sickness. Yet 80 percent of the industrially employed in Kentucky are without in-plant medical or nursing service.

Maternal and child health.—One-half to two-thirds of maternal deaths are preventable by adequate medical supervision during pregnancy. Only one-sixth of total births occur in hospitals. One-fifth of Kentucky mothers do not have a physician at childbirth.

The committee for Kentucky makes these proposals:

Provide scholarships for training men to practice in rural areas.

Make adequate hospital facilities available to all communities.

Local taxation to provide medical care for the medically indigent, with free choice of physician, dentist, etc.

Encourage the development of prepaid medical-care insurance.

Establish full-time health units in every county and provide for their adequate financial support.

CONCLUSION

Most of Kentucky's health problems, just like the rest of the States' health problems, could be solved through a National Health Insurance Act.

OPPOSITION TO S. 545

The Kentucky State Federation of Labor opposes S. 545 because:

1. Two-thirds of the cost of the program must be borne by the States—one-third paid by the Federal Government. (Corrected—see main testimony in the course of the hearing—to read: "The bill requires that States have to put up an amount equal to the Federal contribution, but it also says that States may count in money they are now spending for similar purposes.") This, we think, is unworkable, as many States require from 50 to 75 percent participation on the part of the Federal Government.
2. The bill provides only for proven needy cases—This is not all-inclusive, for it only provides for partial payment for services. This section of the bill places about 69 percent of the population in the "charity" classification. It provides for "relief," but does not consider the rights of the people.
3. The bill provides assistance to voluntary-insurance plans. These plans usually meet only a small part of cost for medical care and do not have a wide coverage.
4. It sets up a new agency and removes some of the responsibilities from the Social Security Administration and the Department of Labor.
5. It establishes a council and provides that six of its nine members be either physicians or health administrators. This means that control will be in the hands of professionals, possibly with lack of administrative ability and perhaps unsympathetic to a continued and broadened program of health insurance.
6. By 1949 the State health agency must take over the administration. We are fearful of the political implications in this feature of the bill.

The Kentucky State Federation of Labor enthusiastically (the word "supports" was inserted during the testimony) S. 1320, because:

1. It states that "The health of the Nation is a national concern," thus placing the responsibility on the Federal Government and establishing the right of the people to expect from its Government a decent health-insurance law.
2. It provides for a board of five persons to administer the law. One must be a physician, but not controlled by professionals.
3. It provides wide coverage and includes voluntary participation of employees of State and local governments. It further provides for civilian Federal employees.
4. It makes special provisions for rural areas which have been woefully neglected.
5. All needed medical services are provided for through the family physician—services of specialists, hospital care, expensive medicines, etc.
6. All employed and self-employed persons are eligible for benefits. Those entitled to old-age and survivors' benefits are also included.
7. Freedom of choice on the part of the patient and the physician is provided for. The law does not compel the individual to participate.

8. The program is maintained and broadened through professional groups who act in an advisory capacity.

9. Hospitals will be paid full cost. Physicians, dentists, specialists, etc., will be paid upon the basis chosen by the majority in the area or by individual choice.

10. It provides for a Federal administrative board, but the administration of services and funds would be left up to local and State boards who know best the problems of the different areas.

S. 1320 further provides for aid to States to expand public-health services; aid for maternal and child-health services; aid for needy persons; and improvement of the Hospital Survey and Construction Act.

The Kentucky State Federation of Labor is interested in the welfare of all the people. We resent the political implications in the struggle over health insurance. The people desperately need and want a good national health-insurance law. It is the right of all the citizens to expect a decent standard of living, and the health of the Nation comes first. Let's make the health standard of our Nation second to none by enacting S. 1320, the National Health Insurance Act of 1947 and defeating S. 545.

Senator DONNELL. Senator Smith, have you any questions?

Senator SMITH. I have no questions.

Senator DONNELL. Thank you, sir; we appreciate your coming.

The final witness this morning is Mr. William Galvin, New York State Federation of Labor.

Mr. Galvin, how long will it take you to testify?

The reason I ask is that we have been here continuously in session since 9:30 with a very brief intermission, and the full Committee on Labor and Public Welfare is due to meet in this room at 2 o'clock.

Incidentally, the members of the committee—and you gentlemen, I assume—have not had any lunch, but we have to go right into that other meeting at 2.

Mr. GALVIN. Mr. Chairman, I think it will take me at least half an hour.

Senator DONNELL. I believe we would not have time to complete your testimony, since it is now 17 minutes before 2. However, we will be glad to hear you after the full committee meeting is over, if you care to come back. You could keep in touch with Mr. Rodgers as to the progress made by the full committee.

The committee is in recess until the call of the Chair.

(Whereupon, at 1:45 p. m., the committee recessed until the call of the Chair.)

AFTERNOON SESSION

The subcommittee reconvened at 4 o'clock p. m., Senator Forrest C. Donnell presiding.

Senator DONNELL. The committee will be in order. Mr. William Galvin, will you take the stand, please, and will you please state your full name, your address, and the organization for which you appear?

STATEMENT OF WILLIAM A. GALVIN, NEW YORK STATE FEDERATION OF LABOR, NEW YORK, N. Y.

Mr. GALVIN. My name is William A. Galvin. I am appearing for President Thomas A. Murray, of the State federation of labor, American Federation of Labor, New York State. I am also president of the State council of bakery and confectionery workers, A. F. of L., and international vice president of the same organization.

Senator DONNELL. Have you been in the confectionery line for some years, Mr. Galvin?

Mr. GALVIN. Yes; 23 years.

Senator DONNELL. In New York State?

Mr. GALVIN. In New York City and New York State.

Senator DONNELL. Would you tell us, please, whether or not you are going to file with us this statement, which I find does not contain your name, but I judge you want it to go in the record? It is the one you are presenting here for the New York State Federation of Labor?

Mr. GALVIN. That is right.

Senator DONNELL. Then you propose to supplement that by an oral statement?

Mr. GALVIN. That is right.

Senator DONNELL. Then your mimeographed statement will be received and made a part of the record to follow your testimony.

May I ask you at this time, Mr. Galvin, who prepared this statement that has just been offered?

Mr. GALVIN. It was prepared for the office of the New York State Federation of Labor, and I believe, though I am not absolutely certain, by David Kaplan, who is now chief economist for the International Brotherhood of Teamsters in the State of New York.

Senator DONNELL. Is he a lawyer?

Mr. GALVIN. No, sir.

Senator DONNELL. What is his calling or profession?

Mr. GALVIN. Seeing the line of your conversation, or rather questioning, this morning I decided to make a long-distance call and find out something about it. He is a graduate of the University of Wisconsin, where he received a degree as bachelor of science, social science, and majored in economics in 1931. He has been an economist on the research staff of the American Federation of Labor for some years, director of research for the International Association of Machinists for 2 or 3 years, and of late, for the last 5 years or more, I believe, has been an economist in the employ of the International Brotherhood of Teamsters.

Senator DONNELL. Do you know whether or not he has specialized in any way in the study of compulsory health insurance?

Mr. GALVIN. As a specialist I would not have anything to say, but from reading his brief and reading the bill, and knowing the sentiment of the New York State Federation of Labor, I have adopted his brief in full as my thought in the matter.

Senator DONNELL. But I mean as to Mr. Kaplan, do you know whether or not he had studied specially the history of health insurance in other countries?

Mr. GALVIN. I don't know.

Senator DONNELL. You don't know whether he has or not?

Mr. GALVIN. No, sir.

Senator DONNELL. Have you yourself, Mr. Galvin, made such a study?

Mr. GALVIN. No; I have not.

Senator DONNELL. Have you had occasion to be in any other countries that have compulsory health insurance?

Mr. GALVIN. No; I have never left the continental United States.

Senator Donnell. And have you read any books pertaining to that subject?

Mr. Galvin. Not recently.

Senator Donnell. When did you last read any such books?

Mr. Galvin. I guess it was back in about 1931 or 1932, during the time I was a student in City College.

Senator Donnell. What were those books you read?

Mr. Galvin. I don't know the titles of them.

Senator Donnell. Can you name any of them?

Mr. Galvin. No, sir.

Senator Donnell. You don't know who the authors are or the titles either?

Mr. Galvin. No, sir.

Senator Donnell. Or how many of them there were?

Mr. Galvin. No, sir.

Senator Donnell. And what college was that you attended?

Mr. Galvin. At that time the College of the City of New York, evening session.

Senator Donnell. Did you have any professor or teacher who was giving any courses in which the study of national insurance or compulsory insurance was a component part?

Mr. Galvin. No; I don't believe so. It was not of so much interest in those days as it has been in the recent past.

Senator Donnell. Are you sure that you read any books on this subject back at that time?

Mr. Galvin. You are asking about insurance?

Senator Donnell. National insurance and compulsory insurance.

Mr. Galvin. I have read books on economics. I don't remember whether or not that was part and parcel of it. As I say, I only remember this thing as dramatized in recent times, maybe more or less in the last 12 years, and especially since the last session of Congress, when we had the Wagner-Murray-Dingell bill up.

Senator Donnell. I will not pursue that in detail further, but I thought you said you had read some books on national insurance or health insurance.

Mr. Galvin. I think you were discussing the remark as to economics at the time.

Senator Donnell. Perhaps I may have mistakenly recalled your testimony. You do not remember any books that you have referred to on either of those subjects, national health insurance and compulsory health insurance?

Mr. Galvin. That is right.

Senator Donnell. Now, will you proceed with your oral statement?

Mr. Galvin. Of course, I don't have to tell the committee that the State Federation of Labor of New York State represents 1,500,000 members, of which 40,000 or more are members of the Bakery and Confectionery Workers Union, and another 12,000 are members over in the State of New Jersey that Senator Smith represents, and we have been thinking about national health insurance for some years in the State Federation of Labor and my own organization.

Senator Donnell. Proceed, Mr. Galvin. I notice in the statement which you have filed, prepared by Mr. Kaplan, that the New York State Federation of Labor is stated to take a position, among other things, that S. 1320 constitutes adequate and effective national health legislation, and that S. 545 does not constitute adequate and effective national health legislation. How was the position of the New York State Federation arrived at? Was it in its annual convention or in an executive committee meeting, or what way?

Mr. GALVIN. S. 1320 represents last year's Murray-Wagner-Dingell bill, with some changes relative to State participation, I believe, which were not in the last bill. That bill was adopted at the last State federation of labor convention. I was on the resolutions committee, and it was passed unanimously just by the committee and passed by the whole delegation. It was also passed by my own bakery and confectionery workers' last convention in September. This bill represents the same theory put forward, with the exception of going into more detail of State participation than did the bill of last year, the number of which I don't remember.

Senator DONNELL. The fundamental principles, so far as compulsion and its application to national health insurance are concerned, you think apply both to S. 1320 and S. 1606? The fundamental principle of over-all coverage of all the people of the United States, rather than only a few or a percentage of the greater number, is in this bill as it was in last year's bill—the fundamental feature of compulsory health insurance?

Mr. GALVIN. Yes, sir.

Senator DONNELL. I say "compulsory" health insurance.

Mr. GALVIN. Using the word "compulsory"; yes, sir.

Senator DONNELL. Have you read personally S. 1320?

Mr. GALVIN. Yes, sir.

Senator DONNELL. Has there been any resolution or other action taken by your organization with respect to S. 545?

Mr. GALVIN. Well, the State federation of labor, as you well know, meets but once a year, usually in July. It ratified the last Murray bill completely, unanimously in convention assembled, and gives its executive board the right to carry forward the theory of the resolutions passed at the convention. Certain whereases in 545 fail to meet the requirements of the resolutions passed by the State federation of labor last year; therefore our executive board decided that it was their duty to come out against S. 545 because it does not meet the requirements of the resolutions that were passed in convention, and come forward and say that S. 1320 does meet the requirements of the last convention.

Senator DONNELL. When did your executive board arrive at such a conclusion with respect to S. 1320?

Mr. GALVIN. Within recent months. I am not a member of the executive board.

Senator DONNELL. Do you have a copy of their resolution?

Mr. GALVIN. No, I have not.

Senator DONNELL. How do you know that was the decision at which they arrived?

Mr. GALVIN. It was told me by the State president, who would be qualified to say that, and I am bringing that from him.

Senator DONNELL. But you have not seen the actual minutes?

Mr. GALVIN. No; I did not see the minutes—not that I recall. They might have sent out a communication on the bill which is in my office, and I probably did not see it or look at in full.

Senator Donnell. Have you read S. 545?

Mr. Galvin. Yes, sir.

Senator Donnell. Proceed with your statement, Mr. Galvin.

Mr. Galvin. There is no argument of the need for national health, no argument to be brought out against working toward a more healthy group of people in the United States.

Senator Donnell. Do you know how the health of this country compares with that of countries which have compulsory health insurance?

Mr. Galvin. I discount a lot of the recent discussions and writings on it, Senator, because of the terrible situation the world has been in in the past several years, and I don't think we can really believe that anything has been properly tried out in any country in Europe, and a lot of things were not properly tried out here, of course, on account of the war situation and the pending war and things that have happened since. I would not want to take anything of that sort and qualify it as something that would go ahead under normal, proper conditions of economics, and, we might say, political.

Senator Donnell. Have you any statistical observations as to the comparative health of this country and other foreign countries which prevailed immediately prior to the Second World War?

Mr. Galvin. Well, I don't think we can go just prior to the Second World War when we consider how conditions were upset in Europe.

Senator Donnell. Do you have any figures of conditions at any time?

Mr. Galvin. What I said before, Senator, was I would discount such figures.

Senator Donnell. I understand you discount them, but I am asking you if you have any figures at all showing the respective health statistics of this country, the United States of America, and foreign countries, at any time from, say, 1850 down to the present time?

Mr. Galvin. No, sir.

Senator Donnell. You do not have any?

Mr. Galvin. No, sir.

Senator Donnell. But you discount any figure that has been issued?

Mr. Galvin. I would discount any figures that were issued—well, at least since 1933, when Mr. Hitler took things over on the other side of the world.

Senator Donnell. Did you examine any figures at or prior to 1933, which were those which you now discount?

Mr. Galvin. No, sir. I said I would discount them.

Senator Donnell. I know, but have you examined them to see what they are before you discount them?

Mr. Galvin. No, sir.

Senator Donnell. So you are just discounting them without ever having examined them?

Mr. Galvin. Yes, sir; just the same as I know the Senator puts things in the record that he believes, whether or not the witness believes them, so I think in my own way if someone gave me figures I would discount them. That is all there was to it.

Senator Donnell. You have not actually seen any figures and haven't any figures in mind at all that you would now discount?

Mr. Galvin. Other than the figures that might have been quoted here today, I have no such knowledge.

Senator Donnell. And you discount all those figures that you have heard here today?

Mr. Galvin. That is right.

Senator Donnell. Very well. Proceed with your statement, Mr. Galvin.

Mr. Galvin. The only question that comes up relative to the need for legislation of this type in order to accomplish a better spreading of good health in the United States has been in the method, and we know there is a desire for such legislation or some comprehensive legislation. The only question is the method of approaching it.

There have been lots of polls taken, and in fact during the New York State problem that they had, in an effort to bring out some sort of legislation relative to compulsory or other type of health legislation, we had a commission appointed during which time a survey was made by a private survey organization, which brought out that 51.9 percent of the persons to whom they spoke were in favor of compulsory health education.

Senator Smith. Who made that survey?

Mr. Galvin. Surveys, Inc., I think, was the name of the company used by Mr. Dewey's commission to make such a survey.

Senator Donnell. Did you see the questions that were propounded to the people who answered them?

Mr. Galvin. I don't remember them specifically, Senator. I was on the health committee of the State federation of labor that did go to visit with that commission and give our own point of view on various things they had before them. But I do know that in the report as recently given to me there were 51.9 percent in favor of compulsory health insurance, and of the ones that voted in favor of compulsory health legislation 48 percent were in favor of Federal legislation on the basis that I spoke to the committee of earlier, and that is the fact that you cannot control health as such merely by State legislation or a State health program. The problem of health is so interstate and so difficult to control through the basis of people going across State lines, and the possibility of their carrying germs and so on with them, and the fact that one State may have a lot of money and be able to spend—as our good State of New York—be able to spend such large sums of money, and another State adjoining it—not New Jersey, Senator Smith, but just as an illustration—might not have adequate funds, and we might be drawing our labor from an adjoining State by people coming in from rural areas to go to an industrial area in the big State. So it is significant then that we must attack this problem on a Nation-wide basis. The methods between the two bills are what I want to bring up.

The Taft bill, S. 545, does give the State the right to come in with an agency and administer the fund, but it does not go down to the very depths, I don't think, of S, 1320, because that particular bill goes in for local administration right down to the lowest spot.

Before going further on that I would like to bring up what I heard here today about the tremendous cost of such legislation. I think Senator Smith brought out the possibilities of cost under S. 1320. Now, as I think I said in our brief—or I accept a statement in our brief—that on formulistic appraisal we will find that the cost of sickness as a national burden is inescapable. We just can't figure it in dollars and cents, Senator. We have got to figure some of the other things than sickness costs in behind the scenes, such as absenteeism, which is a cost to industry and brings out increased prices. It may cause lower productivity on the part of the unhealthy worker, which has the same effect in bringing out increases in cost. It causes increase in industrial accidents, because unhealthy workers usually get into more problems than others, which means that either workmen's compensation must be increased or larger taxes or contributions or something must be done. It causes increased expenses for Federal, State, and municipal public welfare, because as the person grows unhealthy and is without means to take care of themselves they go to these agencies, and finally that means increased taxation. It causes an increase in the expenses of hospitals, whether they be private and endowed by other people, or city or State, and therefore endowed through taxation.

It causes reduced payments of taxes on the part of the unhealthy worker himself, because he misses more work and has less income, and consequently pays less taxes. So the cost of ill health is instable, and it is a question of how we should approach it.

In its preamble, I might say, or in the "whereas" clauses, Senator Taft's bill—and your bill, gentlemen—brings out a very laudatory point which, if it were followed through, would be much more costly in taxation to the general public who pay taxes than would S. 1320—and I refer to page 2, line 12, which is section 2 (c) of the bill—and very well put, I think, as the policy—

> That it is the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status.

Of course, the emphasis was my own.

Your bill does not do that. Your bill goes down into being one that only reaches the low-income group.

Going down the line in the bill, the Taft bill—if you will, S. 545—the first thing it does, it brings into being a doctor administrator of the law, and, naturally, it brings into being our American Medical Association, which up until the introduction of this bill has fought every type of National and State-wide and country-wide health program in which they did not have complete control. Here they are willing to support this with a lot of "but's" and "and's" and "maybe's." But they are going to have control. Not only from the administrative point of view, but all along the line, wherever a committee is to be formed, the majority of the committee is to be of the medical profession—sort of a medical closed shop, if you will.

The bill itself, of course, goes only toward taking care of the low-income group. It means the detestable and very unfortunate business of everyone who finds himself in a position where he cannot pay his bills, even after having attempted for a time to pay them, that person must immediately go and try to get, through whatever means he can, some help from a State agency. It means charity as against the possibility of a person contributing to his own insurance.

One part of the bill calls for a migration of doctors to rural areas. I don't believe that will bring anything but probably the least efficient, who will be wiling to migrate.

And Mr. Taft himself has said that this bill will only reach 25 percent of the people of our United States, which, to my mind, is not attempting to be general enough to cover the real problem.

Senator SMITH. Let me interrupt you there, Mr. Galvin. You are not quite right in the implications of your statement. The bill recognizes that probably 25 percent is the percentage that needs covering outside of those normally covered now. We are trying to meet the uncovered part. The bill contemplates complete coverage but not by the method you propose that the Government could do it.

Mr. GALVIN. Senator, what do you mean by "normally covered now"? You say 25 percent are not covered.

Senator SMITH. I mean 75 percent of our population certainly is taken care of medically now through present processes, and we are trying here to take care of the 25 percent who are unable economically to meet the expense of medical care. The bill does not aim to give Government coverage to 90 percent of the population, as was claimed by Dr. Boas yesterday, as S. 1320 does. We don't believe that that can be done. We don't believe it is practical; that is the difference. It does not mean we are ignoring the few. We think that the call is to meet the vacuum. That is our position.

Mr. GALVIN. Regardless of the method of approach as to how that person can get that medical care?

Senator SMITH. Not regardless of the approach, but that we think that is the best method.

Mr. GALVIN. That is all by the medical profession.

Senator SMITH. We think granting aid to the States, setting up their own medical boards, as the bill provides, is the most practical way, the trial-and-error way, to get our results, rather than trying to group the things together all at once and have the Government run the whole show.

Mr. GALVIN. There is a difference of opinion there.

Senator SMITH. You are asking for a complete revolution in our whole method of health programs, and as Senator Donnell started to ask you, if you were able to give the figures comparing standards of health in the United States with those of any other country in the world—take the South American countries, that have not had a war—the comparison is just startling if you will get the figures. We have done a great job in this country to fill those vacuums, but we admit there is need to take care of the people who, through misfortune, are not able to take care of themselves, and we think that society has that responsibility, but not to the whole population. The more independent the people are to work out their own salvation and pay their own bills the better it is for the Government.

Mr. GALVIN. You believe then that, if I could afford $1,000 for medical and surgical aid, and I went to a hospital and stayed there as long as I could with that $1,000, plus all the other bills that I have, and plus lack of income at the time that I am away, that I should then go out, whatever happens to me, because I have run out of money, or should then throw myself on the charitable organizations, even though by spreading it through insuring myself over the time, I might have been able to pay whatever was needed?

Senator SMITH. And everybody should work for the State and the State should take care of everybody? That is State socialism.

Mr. GALVIN. No, sir; I disagree with you. Your bill is socialism because you are saying that the state alone, without any contribution from the worker or the indigent person, must take care of everybody regardless—I will go along with you that they should be taken care of.

Senator DONNELL. Where do you find that in the bill?

Mr. GALVIN. Because it leaves to the State the money used by the State. There is no control by the State government and not even the United States Government as to the relation to the money and use of the money, not even as to minimum standards of health, or hospital, or anything else.

Senator DONNELL. Is there one line, jot, or tittle in S. 545 that says that all expenses or any particular item of expenditure here shall be borne by the Government?

Mr. GALVIN. 50 percent or 33⅓ percent, in whichever section you want to look at. And you are proceeding to give that money to the States without any control whatsoever, and that is state socialism within the State, if you will, sir. But I am not going to argue, because we disagree on this or that method, that they should go without care.

Senator MURRAY. Mr. Chairman, I would like to listen to this witness and hear what he has to say. I don't think it is quite fair for both to be talking at the same time. We can't get it in the record.

Senator DONNELL. Will you proceed with your testimony, Mr. Galvin?

Mr. GALVIN. Now, again, just to point up the point I was discussing a moment ago, S. 545 decentralizes not only to the extent that it sends money to the State agency to be used for certain purposes, but not any controls, minimum or otherwise, while S. 1320 even goes down to the local community, to the local committees, and maybe even to the county medical association. I again say that points up the fact that the money is just thrown to the States, to one man in the State. I don't remember whether he has to be a doctor or not. He is the fellow that says what goes on with that money, with an advisory committee, even as the medical people have complained, with no powers whatsoever but just to advise.

There is no preventive here in S. 545, as there would be under S. 1320, except as to dental examinations of school children. Then after we find out whether they need care, we have got to find out how much their mothers and fathers make, in order to find out whether we can give them care. And that is again going down into the lower-income brackets.

In the main your bill, it cannot escape me but that the American Medical Association, even though it is in favor of it, is only in favor of it because it maintains a majority control about all the way down, and I think even the American Medical Association, with all the "buts" it has put in, is not in good faith in this bill.

To give a group of doctors full power in running this whole program is not my idea of the American way of life, not my idea of the—this is a bad expression to use before Republican Senators, I know—it is not my idea the way we should consider the problem.

Everyone is interested in public health. The doctors are the only ones that make their living from it, or if I may say, make their main living from it, and who will say right off, like in S. 1320, when it comes to professional problems, what the efficacy of the situation is, who are the specialists, what type of care should be given, and so on, and professional committees are set up to give that advice to the advisory committee, which in the majority of cases is not medical men, and getting into it real deeply, it is my belief that they have as much real power and they have as much to say and as much advice to give and as many possibilities for themselves in the profession under S. 1320 as they have under S. 545, except when it comes to the highest top, where they have majority, and where they have the administrator and everything else. Again I say it is a medical closed shop, and we have just seen that Congress passed a law against a thing like that recently.

We know that the State of New York will not go any further in its services, with the exception of about $13,000,000, which it has been suggested will be apportioned from the Taft bill to the State of New York because of its proportionate population, and so forth. However, some other States that could not meet their population proportion will not get all of that money, other than if they go into taxation and that means an increase in taxation in many States, and even these hidden things are tremendous increases in taxation, and it should be said for the State of New York and the American Federation of Labor in the State of New York that we believe that when you make a comparison of the advantages of the 1946 Wagner-Murray-Dingell bill over the Taft bill you will see that one has insurance as against charity; one goes toward comprehensive medical care, and the other, the Taft bill, to incomplete medical care because of the financial end of it, as well as every other way.

The effort on the part of S. 1320 would, through its grant-in-aid, be to increase the supply of doctors in hospitals, and so forth, and the effort on the part of S. 545 will be more or less to spread doctors in the rural areas, whom we have already drafted from their places at home.

The fact has been agreed upon, with the possible difference of opinion between Senator Smith and myself, that the Taft bill covers approximately 25 percent of the people, and the effort on the part of the payroll deduction plan, which ultimately will come out of 1320, will cover 80 to 90 percent, and then we know that the words about where a person was not working, was not contributing to the fund, and therefore was definitely needy—even in that sense there is the provision ultimately to take in a person who cannot work, has not worked, is not putting anything into the fund, and pays insurance through 1320. So that what the Taft bill does in the beginning and goes no further, the Murray bill goes on to make an effort to cover the whole community. And I say that my brother is my problem. If he is sick, no matter where he is, whether rich or poor, I have a problem, and anything that hurts him while he is sick, hurts me or hurts anybody else. We all have problems, and the problem of a man being ill or sick is the problem of the whole United States, and the fact that insurance will help take some of the weight off the entire over-all cost of this bill which, if we carry it out, is only $200,000,000. We must go into it immediately and try to, within, I think the 5 years that is provided for in S. 1320, build up a method in every State whereby we can see that every purpose of preventive medicine and all the other coverages in S. 1320 may reach as many other people as we possibly can and keep them healthy, so as to make our country in this day and age not in the position of rejecting men for the armed forces and so on, if such a thing were forced upon us in the future. It will be less cost in the long run to the United States Government to help, and will help in the idea of less taxes.

There is more decentralization in S. 1320 than there is in S. 545. And again I say that preventive medical care is a very important thing, and the people's control against complete doctor's control. I am not asking for labor-union control or anything like that, but a couple of social workers, as we know we have many qualified in the States, in the United States, could serve on those boards and be of great help. It doesn't require a majority of doctors or a doctor as administrator. It has been said, and while it is not 100 percent true, but in many of the great hospitals of this country they have administrators that are laymen, because that requires a lot of technical book work that a doctor has not been particularly trained for, and I think it has been brought out definitely before that all the people of the United States want national health legislation, and if we are to say——

Senator DONNELL. All the people of the United States?

Mr. GALVIN. I will say a majority of the people want it whether it is compulsory or not. I am not arguing that.

Senator DONNELL. You are talking about some type of insurance?

Mr. GALVIN. Some type of health-insurance legislation.

Senator DONNELL. You are not arguing that you have any proof that the great majority of the people want compulsory national health insurance?

Mr. GALVIN. The only thing I offered you was this survey by the commission appointed by Governor Dewey in the State of New York, which brought out that 51.9 percent of the people they met wanted compulsory health insurance, believing it to be for the betterment of the whole community, not for themselves individually.

In the final analysis we are opposed to the Taft bill because it does not scratch the surface of the problem. It does not give proper balance to doctor and people control. It does not do anything to avoid the means test, and I tell you gentlemen I have been under means tests when I was a young fellow, and I know what it means. I have sat in clinics that had signs in them which said: "If you are in here and you can afford to go to a doctor and pay yourself, you are guilty of a misdemeanor and you are going to be fined such and such, and sent to jail for so and so."

I used to sit there with the $11 a week I was making and wonder whether or not I was implicated in this, and after going two or three times to the clinic I finally wound up with an operation at City Hospital for nothing. I know how I felt, even though I was indigent medically, and I know that if we can avoid that and it would only be the extreme cases where a person knows they are not working, have got nothing to pay, where it won't be a qualification between me and you as to whether or not I can stretch another dollar out of my income for medical services, that will have a lot to do with the success of health legislation in this country. It will go toward the failure of the Taft method, because many people who need medical attention fail or refuse to go through that method of getting it, people who are earning just a little and are afraid that they might be knocked down by some bureaucrat or some doctor.

All in all, gentlemen, I believe you should attack this problem—if I may use Senator Smith's method of approach to the problem—that you should attack this problem as one grand over-all problem, because it is one grand over-all United States, and we have to worry about the health of all the neighboring States as well as the neighboring cities. The Murray-Wagner-Dingell bill is not up now, but the Murray-Wagner-Pepper-Chavez-Taylor-McGrath bill certainly does go to the heart of the problem. It is a good bill so far as the New York State Federation of Labor is concerned. I can't talk for the American Federation of Labor nationally. They have their own people to do that. Mr. Murray asked me to come down and express his views as best I could, and to submit this memorandum which you have received copies of.

Senator DONNELL. Senator Murray, do you desire to ask any questions?

Senator MURRAY. You have had considerable experience in your State with grants and relief programs, have you not?

Mr. GALVIN. Yes, sir.

Senator MURRAY. Could you tell the committee just why you place such emphasis on the means test?

Mr. GALVIN. Well, there is one illustration I gave you out of my own personal life. During all the relief situations and during all the time that people were going, as they still do, to clinics, there is this thing to say, that it is a shameful thing. Everyone knows you are in that line because you haven't got the bucks to pay for it. You look at your neighbor and look at the next person and hope you will never see them again, and they should never see you. You see them and you cringe. Of course, some people go boldly into anything and take what they haven't got coming to them in those situations, but I know kids on the West Side living there, not having enough money for medical care or anything else. However, I do know that if you happened to pass one of those lines years ago, when you were not on the line, and you see the people on there—we hope we never come back to it—we see them cringe, one from the other, and it lowers your self-respect to such an extent.

Now, when we go in as we do under S. 1320, we go there only when we know there is a person that is not working and cannot contribute. It is not really a means test. There is an absolute picture usually of the situation. It isn't a question of coming in and saying: "Now, I am making $30 a week. It costs $30 a month for rent. I have so many children," and so on, in order to get maybe a $2 visit to the doctor. My own international, my own local union, is fairly far advanced in trying to take care of our people. We have free doctor service, but without any excess cost on our own membership. We have always had it since my union organized in 1934. Our international union pays sick and death benefits, but those things are all coming to the lads because they pay dues, and they have it coming to them, but when I have to go up and argue with some, as I say, "bureaucrat" who is going to tell me whether I can get $2 or get some treatment free, I can't stand that. I can't see any of my own people having to do it, and I don't think anybody would want to.

Senator MURRAY. The means test is particularly abhorrent to people who have sought, during their lives, to maintain themselves and their families, but when they come to a point where they find themselves unable to provide their families with medical care, or themselves, they feel very seriously about going and requesting public assistance in a matter of that kind?

Mr. GALVIN. Yes, Senator. I could probably with my salary reach the point where medical care for my own home, my own family, would be so high that I could not pay it. Then, of course, it would be my duty to go around, sneak around and borrow some money from a bank or a money lender or somebody else, because in the future maybe I will have the ability to pay, but if I myself were sick and my wages were cut off, then I would have, after having had the ability to pay all along the line, and I had the ability to pay, then I would have to come in only when a person finds himself unable to pay for sick bills, then do they come for this Taft Act. At least under the Murray bill we will be insured. We will have the right, regardless of how expensive it is.

And I take exception to Senator Smith—the chairman can take on for him—that the cost is hidden in all these days of loss of work, all the loss of income, all the unhealthy workers and everything else along the line. And it even has bearing in labor relations itself, because all of these things are brought up, and the mere fact that it might require more taxation in the beginning or anything else like that is just a case where we are against a tax, and there again the burden is upon the people that can pay taxes.

The Taft bill—I hate to use the word, but it is a stopgap that just doesn't meet the obvious needs of the situation, and we of the State federation of labor must very definitely go on record as saying it is inadequate and does not reach the needs of the situation, and that S. 1320 constitutes an adequate and effective national health legislation.

Senator MURRAY. Some effort has been made to compare the health of the people of this country with other countries of the world. Do you think it is possible to make a fair comparison between the health of the American people and the health of people of other countries? For instance, take England. The English working classes were never in the same situation as American workers with regard to earning sufficient income to take care of themselves, never were able to eat as well, never had as good health conditions surrounding them as they have had in this country.

I understand that 30 or 40 years ago the health of the women of England was in a frightful state. I have been told by people who have visited the big industrial centers there that the women of England 30 years of age had no teeth, that they were in a very poor state of health, and that that is true in some other parts of the world as well; whereas, in America we have had a whole lot better conditions in every respect, better surrounding conditions, that make it possible for people to live healthier than they could in other parts of the world.

So it would not be easy to make any comparison between the health of American citizens and the health of people of other countries under any kind of health-and-medical-care system that they may have.

You say you have never made any study of compulsory health insurance in other parts of the world?

Mr. GALVIN. No, sir. I have been told that there are about 35 countries that have compulsory insurance and that once they started it they kept it up, and some people say that is the usual thing, that once you start something with taxes and everything else involved, they continue it. I don't think they should give it that over-all tax. I think even if we had, Senator—and I don't imply anything other than what I have been saying—even if we had the highest health rate in the world, we cannot afford to even take a chance that it will slip back a little bit, and we should go on to the clearest goal that we can, as close to 100 percent perfect health in man, woman, and child.

I think your bill, Senator, goes toward that goal, with the necessary tax that the working man will pay. But if I may quote a rather illustrious Missourian, in a speech to Congress on May 19, 1947, he said:

> The national health-insurance program is a logical extension of the present social-security system which is so firmly entrenched in our American democracy.

Someone else once said—and I was here quoting the President of the United States—someone else once said that it was the logical conclusion in a mature democracy. We are not in any way espousing—our memorandum submitted says that—any foreign ideologies. You are looking at a representative of the State federation of labor who stands foursquare against anything that is anywhere near communist or fascist, and all of the members on the executive board of the State federation of labor can be qualified in the same way. But this is democracy. I think democracy is a Government that tries to take care of the people. We have gone a long way on education. The only quarrel we have had with it from time to time is the cost of it. But our people can stand up even from what is supposed to be the backward States, against all types of people all over the United States, and I think everybody was very much interested to see the little girl from Mississippi just win the national spelling bee. If you had suggested 20 years ago that somebody from down there would win the national spelling bee you might have said, "Well, they don't have an education for it." But this young lady stood up in radio competition and won the spelling match.

We have gone far in education. We must now go as far in health. I disagree with Senator Smith, and I imagine with Senator Donnell, in feeling that we should go slowly in this. I think the picture is there for everyone to see. I think it is a broad enough picture for any Senator of the United States or anybody to grasp, and at the same time I think they could honestly go ahead with it, and as long as they divorce control from it and take out this means test and go on for the insurance angle of S. 1320—in fact, I have heard some people speak here today that were in favor of the Taft bill and wound up giving all the exceptions that became exceptions, which they took out of the Murray bill and put into the Taft bill. The only thing they wanted to retain was doctor control. I think even the doctors would want to accept it if they could get full control of it. Unfortunately, that would not be, to my mind and the mind of others with whom I have discussed it, the best thing for the country. The doctors were very glad to accept the system in the Veterans' Administration, where they were permitted to determine just exactly what kind of service should be rendered, the compensation to be paid for it, everything with reference to the administration.

There has been considerable reference here to the Selective Service records.

Senator **Donnell**. There has been considerable reference here to the Selective Service records. Have you made any investigation of what the Selective Service records have shown with reference to the indication of lack of medical service in this country?

Mr. Galvin. Well, I don't know, except I know something about what happened in the State of New York. And then we get some reports that were brought in to the committee here last year, I believe—the report of the subcommittee here in July 1946 that Selective Service data shows that over 40 percent of the young men and women of draft age were found unfit for military duty; at least one-sixth of these had defects which were remedial; many more had preventable defects. This is a shameful and inexcusable weakness in our Nation. The facts were disclosed by the final report by the chairman of the Subcommittee on Health and Education to the Senate Committee on Education and Labor, subcommittee report No. 16, July 31, 1946.

The State of New York has some figures that run similar to these, gentlemen, if you will bear with me. In the State of New York——

Senator Donnell. What is your authority for the information you are about to put in the record now, Mr. Galvin?

Mr. Galvin. This was compiled from New York fact sheets supplied, I believe, by the American Federation of Labor research department, which you can disagree with as to some of the information if you will. It says relative to the State of New York that we have one physician for every 597 people in 1940, which made us the second lowest, with all our expenditures; 1 dentist for every 1,321 people, which made us third lowest; 1 professional nurse for every 698 people, which has no comparative figure; 1 public health nurse for every 4,168 people in 1941. The per capita local health department expenditure in 1942 was 99 cents, which is the third highest. Even with that we had a rejection rate per 100 registrants from February to August 1943 in the State of New York, exclusive of New York City, of 37.7 the eighteenth lowest in that category.

Central registrants, having no defects, April 1942 till March 1943, 38.2, twenty-first highest in that respect.

Percent of distribution of principal causes for rejection are such as this: Mental disease, 17.6; cardiovascular, 9.6; hernia, 9.5; muscular deficiency, 8.4; ears, 7.4; neurological, 6.9; eyes, 6.9.

Now, gentlemen, I am certain that in our advanced stage of intelligence, even from what we get from our doctors, some of those that have been mentioned certainly were preventable or operable at some time or other. If hernia could have been cured at an early stage or prevented, in the sense that if on examination a person finds they have a hernia, and they are young enough, they can go and get it taken care of. I have a good deal of responsibilty in my own organization relative to workmen's compensation, and I know how we have every year an annual examination and find hernia that they never knew they had.

Having to do with ears, I don't know what can be done, but certainly something can be done about eyes in preventive medicine.

Mental diseases we know come from many sources, but sometimes can be prevented if the person is taken in hand early enough.

I notice, without reading it into the record, that S. 1320 goes into great detail as to the type of services that will be given, and many of them are preventive, and many of them are very important, but the fact that a person can go to a doctor, gentlemen, 10 times if he has to—and that is with our local union experience—we pay the doctor's fee, and the person can have a doctor 10 times if he wants, or any member of his family in case they get injured or get sick. And then there is no idea that they are stealing anybody's money. They pay their dues and they are just as well off as anybody else. And they can go for examination. Children go for examination, and they keep them on preventive medicine, and many of the things for which our boys were rejected during the past war could have been prevented, and if we are to be ever brought into such a situation that we have another war, certainly any type of preventive medicine today will go far toward a better and stronger nation when that time comes.

Senator DONNELL. Mr. Galvin, we are very much obliged to you for your testimony.

Mr. GALVIN. Thank you for your attention, sir.

(Mr. Galvin submitted the following brief:)

BRIEF SUBMITTED TO HEALTH SUBCOMMITTEE, SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE, RE NATIONAL HEALTH LEGISLATION, S. 1320 (1947 WAGNER-MURRAY-DINGELL BILL) AND S. 545 (TAFT BILL)

SCOPE AND PURPOSE OF THE BRIEF

This brief is divided into three sections:

I. Comments concerning national health legislation generally.
II. Comments concerning S. 1320 (1947 Wagner-Murray-Dingell bill).
III. Comments concerning S. 545 (Taft bill).

The New York State Federation of Labor, after careful consideration of the subject matter, takes the following position:

I. That the prompt enactment of adequate national-health legislation is not only desirable but is essential to the public welfare.

II. That S. 1320 constitutes adequate and effective national-health legislation.

III. That S. 545 does not constitute adequate or effective national-health legislation.

These points will be considered in the following pages of this brief in the order above stated.

I. THE NEED FOR THE PROMPT ENACTMENT OF ADEQUATE AND EFFECTIVE NATIONAL-HEALTH LEGISLATION

It would seem that there could hardly be a difference of opinion among reasonable-minded men as to the desirability of improving and maintaining the health of the Nation. And yet, all too frequently, we find that it is commonplace truth which escapes our attention, while we devote our energies to more distant matters. We beg leave, therefore, to stress the commonplace and belabor the obvious for a few moments, upon the ground of the great urgency of the matter before us.

The primary national asset

Balance sheets and inventories notwithstanding, it is manpower which is the primary national asset. We speak not of manpower in the abstract, as so many millions of humans, but rather in the full sense of the word, as so many millions of normal, healthy workers for democracy, sound and active, both physically and mentally.

The natural resources of the United States, of which every schoolboy is aware, and which we have come to think of as "constitunation," were here long before our Nation was populated as it is today. But for centuries, while this continent was populated by a scant number of savage people, those resources were stagnant and meaningless. They were potential rather than actual. They have become real and meaningful only because of the development of our great national manpower.

We have been through a war which has demonstrated, even to the dullest, the overwhelming importance of marshaling great manpower in the defense of the Nation. Massive production, which only huge and healthy manpower could accomplish, was the decisive factor in the war. We have observed, too, how profoundly helpless are large nations, such as China and India, whose total manpower, in the abstract sense, exceeds our own by far, because that manpower is unorganized, weak, and sickly.

Foreign governments, some of which have been based on ideologies repugnant to us, have not in recent years been aware of the supreme importance of healthy manpower. Neither Nazi Germany nor Communist Russia ignored this problem. We participate today in an alert and scientifically minded world society in active competition with many enterprising nations of diverse modes of thought and philosophies. We should not fall behind any of them in developing our greatest national asset. To fall behind in this is not merely to lessen confidence in our own form of government; it is also to reduce our vital strength.

The enactment of national health legislation is urgent. It cannot wait upon tomorrow. Complacency is not justified, merely on the ground that in many respects our national health compares favorably to that of other nations. That which is significant is the fact that our national health is so far below what it might be that we have hardly begun to develop our potential strength. Natural resources, no matter how abundant, are not infinite; as such resources become limited, the prime factor in the success of nations will be the development of healthy manpower with which to exploit and utilize those resources to the fullest extent. We should not be slow or tardy in that endeavor. Perhaps the most dramatic current illustration of the need for prompt consideration of a national health program is the development of biological warfare. It is centuries too late to dream that health is an individual or a municipal or a State problem.

The cost

Upon realistic appraisal, it will be found that the cost of sickness, as a national burden, is inescapable. It expresses itself in the following ways, among others:

(*a*) Absenteeism (cost to industry, and thence to public by way of increased prices);

(*b*) Lowered productivity of unhealthy workers who do not absent themselves (same effect as above);

(*c*) Increased industrial accidents by unhealthy workers same effect as above, but also transmitted through additional costs to insurance companies furnishing workmen's compensation insurance, and transmitted to public by way of larger premiums, larger taxes, or contributions, and higher prices);

(*d*) Increased expenses for hospitals (private hospital costs transmitted to public through contributions, endowments, etc.; public hospital costs through taxation):

(*e*) Increased expenses for Federal, State, and municipal public-welfare agencies (increased taxation);

(*f*) Reduced payment of taxes by unhealthy persons of low earning capacity (increased burden of taxation upon remaining population).

The cost of ill health being inescapable in one form or another it follows that we do not add to the national cost by providing a national health program. What we do instead is to give frank recognition to the cost and deal with it honestly and openly. We do more, however. We reduce the cost by reducing illness. There is therefore a double accomplishment in that (1) the cost is frankly recognized and distributed rationally, and (2) the cost is reduced by a direct and coordinated attack upon its cause.

Inadequacy of local programs

Illness knows no jurisdictional bounds. Ill health is contagious, both literally and figuratively. Our significant commerce is organized along interstate channels. Poor health in a rural area directly affects an industrial establishment across the line in the next State which draws its labor supply from that area. In the literal sense, ill health in epidemic form crosses State lines with utter impartiality. No wealthy State within our Nation can protect itself, no matter how lavish its expenditure, against direct and indirect invasions of illness from a poorer or less enlightened neighboring State. The attack upon illness must be organized nationally.

Whether because they cannot do it or will not do it is beside the point; the fact remains that our State governments have not provided an effective health program for the great mass of our citizens. This is demonstrated by the following facts which are verified beyond the need for controversy:

1. Selective-service data show that over 40 percent of the young men and women of draft age were found unfit for military duty. At least a sixth of these had defects which were remediable. Many more had preventable defects. This is a shameful and inexcusable weakness in our Nation. These facts were dis-

closed by the final report from the chairman of the Subcommittee on Education and Labor, Subcommittee Report No. 6, July 31, 1946.

2. At least 7,000,000 people in the United States are incapacitated by sickness or other disability each day. Of these, half are disabled for 6 months or more. See testimony of J. Douglas Colman, on behalf of Blue Cross Commission, before Subcommittee on Labor and Public Welfare, May 23, 1947.

3. Approximately 40 percent of the counties in the United States do not have a single full-time local public-health officer. See interim report from the Subcommittee on Health and Education to the Senate Committee on Education and Labor, Subcommittee Report No. 5, July 1946.

4. Forty percent of the counties in the United States, having a total population of approximately 15,000,000, do not have a single recognized hospital. See Subcommittee Report No. 5, supra.

5. In 1944 there were 535 counties which had less than one active physician per 3,000 population. Even 1 per 3,000 is considered as "danger line." See Subcommittee Report No. 5, supra.

6. The American Medical Association reported, as far back as 1939, that persons with incomes under $3,000 per year were unable to pay in full for medical costs. In 1945, a peak year, 69 percent of the population had family incomes of less than $3,000 per year. The devaluation of the dollar since 1939 aggravates this situation tremendously. It is obvious that far more than 69 percent of our population requires assistance in order to obtain comprehensive medical care.

II. S. 1320, THE 1947 WAGNER-MURRAY-DINGELL BILL

Upon careful consideration we believe that S. 1320 constitutes a fair and well integrated national health program and we urge its prompt passage. We present below a brief statement of some of the principal factors upon which we base our conclusion.

Regard for State interests

Those who glibly argue that national treatment of health problems ignores local needs and generates an all-pervasive Federal bureaucracy have not studied S. 1320. This bill gives evidence of careful consideration of varying State resources, and the solution which it provides is commendable. The treatment is not that rigid command from above. On the contrary, the role of the Federal Government under the bill is that of an assistant and a coordinator. It is explicitly provided in various parts of the bill that, to the fullest extent possible within the broad framework of the Federal act, each State shall be free to administer to its own peculiar needs in its own peculiar way, it being required only that certain minimal standards be satisfied. Part C of the bill expresses the policy of Congress that—

"* * * responsibility for administration of benefits * * * in the several local health service areas shall be decentralized as fully as practical to local administrative committees or local administrative officers * * *" (sec. 231).

Part D of the bill provides that—

"* * * The benefits provided under this title be administered wherever possible by the several States * * *" (sec. 241).

Freedom of action

S. 1320 does not dictate to the patient nor to the physician.

The patient's freedom of choice is protected by providing (sec. 203) that the patient:

"* * * may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection. * * *"

On the other hand, physicians, dentists, nurses, and hospitals are guaranteed freedom of action by the proviso (sec. 203) to the effect that they are not obligated to render services under the act unless they have agreed to do so.

No segregated panel of physicians or dentists is created by this bill. All physicians and dentists "legally authorized in a state to render * * * services" are deemed qualified to act under the bill (sec. 211).

Insurance versus charity

A vital distinction between S. 1320 and S. 545 is that the former provides health insurance as a matter of right to the entire citizenry of the United States, whereas the latter is a sort of pauper's bill which condescends to offer public charity to "needy" individuals.

S. 1320 grants substantially universal protection. It covers both those who are employed by others and those who are self-employed (sec. 204). Virtually all employees in industry, commerce, agriculture, and domestic service are included (railroad workers excepted). Farmers, business, and professional men are likewise covered. The wives, children under 18 (also over 18 if disabled), disabled husbands, and dependent parents of insured persons are also eligible for benefits. Through pay-roll deductions, S. 1320 will cover from 80 to 90 percent of the population, and there are further provisions which insure virtual 100 percent coverage.

This broad and general coverage is essential. Illness of any portion of a family or community drags down the remainder of the group to the level of the afflicted. A nation cannot afford to be half sick and half well. Those who are overburdened by the illness of their dependents cannot be fully efficient workers for democracy.

To provide help only for the "needy" is to miss the point. The function of national-health legislation is not to grant mercy to the afflicted. Its true function is to fortify the Nation by improving and preserving the general health. This can be achieved only by universal coverage without sitgma of pauperism.

General considerations

The New York State Federation of Labor, and the American Federation of Labor, with which it is affiliated, are staunch supporters of American democracy. We hold no brief for foreign ideologies. We stand firmly, however, for the constant development and strengthening of our democratic system of government, to the end that it may compete vigorously with all other forms of government in a scientific and aggressive world. This Nation cannot protect itself by lip service to democratic ideals. We must constantly achieve those ideals in an effective manner in a changing world.

Health Insurance is a natural and necessary development in a mature democracy. From the point of view of management-labor relations it is apparent that universal health insurance lessens rather than aggravates tensions between employers and employees. Healthy, unworried workers can approach their labor problems objectively. The elimination of urgent personal problems permits a more sober appraisal of the true economic factors involved in labor disputes on the part of both management and labor. Passion and the crackpot schemes which it generates are far less likely.

We believe that S. 1320 is a progressive and effective step in the direction of improved management-labor relationships.

III S. 545 (TAFT BILL)

As has already been pointed out, one of the major defects of S. 545 is that it is focused upon aid to the "needy." It thus misses the point completely, for the great need of our Nation is not to extend charity to the poor in a spirit of mercy, but to strengthen the Nation by improving the health of all, whether rich or poor.

The sole obstacle to general health is not poverty per se, although that is a great obstacle. For example, another great obstacle is the psychological barrier which is erected when, as a condition of obtaining medical aid, our citizens are required to pauperize themselves. S. 545 is completely blind to this factor. Another great obstacle is inadequate education concerning the availability and the benefits of preventive and curative medicine. Only by a comprehensive and well designed plan can these matters be brought home to the great masses of our people. S. 545 does not begin to accomplish this purpose. It is acknowledged that, despite an appropriation of $200,000,000, S. 545 would give assistance to no more than 20 to 25 percent of the population in need of medical care.

S. 545 places undue reliance on the medical profession itself to administer the medical care program. Doctors are no better or worse than other people. It is unfair to expect them to be free of self-interest. It is unrealistic to expect them to resist the pressures of selfish groups and lobbies within their profession. To rely upon the medical profession is, in the good old American phrase, to pass the buck. The national health program must be developed in effective form by Congress, because it has been demonstrated that these matters do not take care of themselves.

S. 545 makes no provision for grants-in-aid for medical research and education or construction of health facilities. S. 1320 does.

S. 545 attempts to move doctors to poor areas by subsidizing them; in other words, it offers bait to the incompetent and the mercenary. S. 1320 accomplishes better distribution of doctors and hospitals by its general insurance plan, because when people in poor areas are entitled to medical care and have free choice of doctors and hospitals, their demands will necessarily produce a supply of competent doctors and adequate hospital facilities.

CONCLUSION

Carefully consideration demonstrates that S. 1320 is a well designed and comprehensive bill which will establish a health program in an effective democratic manner. On the other hand, we find that S. 545 is a hasty, stopgap measure which, while calling for an extremely large appropriation of money, discloses failure to grasp and deal with the basic national health problem.

The New York Federation of Labor urges the prompt enactment of S. 1320 and opposes enactment of S. 545.

Respectfully submitted.

New York State Federation of Labor,
American Federation of Labor,
Thomas A. Murray, *President.*
Harold C. Hanover, *Secretary-Treasurer.*

Senator Murray. Mr. Chairman, before you recess, this morning there was some reference made to the report of the Committee on Health for Kentucky. I will ask that this report be made a part of the record.

(The document referred to follows:)

A Report on Health

(By the Committee for Kentucky, a fact-finding committee whose objective is the welfare of all of Kentucky)

FOREWARD

This is the third report presented to the people of Kentucky by the Committee for Kentucky—a fact-finding organization that has as its only objective the welfare of all of Kentucky.

The first report was on agriculture and was made by Dean Thomas P. Cooper, the distinguished head of the experiment station at the University of Kentucky. The second report on education was made by Dr. Maurice F. Seay, one of the foremost experts on education, not only in Kentucky, but in the Nation.

It is fitting that the report on health should be made by the eminent State Health Commissioner of Kentucky—Dr. Philip E. Blackerby—since his is the chief responsibility in our State for public health.

Most of the facts presented by Dr. Blackerby clearly highlight some of the deplorable conditions of health in Kentucky. These facts are offered to the people of Kentucky, not in any sense of destructive criticism, but rather as a challenge to all Kentuckians to roll up their sleeves and go to work to correct the conditions that need correcting.

We of the Committee for Kentucky are confident that an informed people will begin to demand solutions. Having complete faith in the democratic process, we are equally confident that once the people begin to demand solutions they will get them. We feel, therefore, that a better day is coming which will provide for all Kentuckians an opportunity for a fuller and richer life. Certainly that is something that should be the heritage of every Kentuckian—in fact of every American.

There will be other reports to follow this one. We urge every Kentuckian to read every one of them, for only the people of Kentucky can correct the ills of Kentucky, and only the people of Kentucky can restore Kentucky to its former greatness.

Harry W. Schacter,
President, Committee for Kentucky.

CALLING KENTUCKIANS TO GOOD HEALTH

We are a proud people, proud of our Kentucky traditions, our bluegrass, our mountains, immensely proud of being Kentuckians. We like to point with pride to the great progress made in the field of health in the last quarter of a century. We note that the tuberculosis death rate has been cut in half; that deaths of mothers and infants and deaths from diarrhea and enteritis have likewise been cut in half; that the diphtheria death rate is only one-tenth, and the typhoid-fever death rate is only one-fifteenth the former rates, and that smallpox has become a medical curiosity.

But while we may be justifiably proud of our health accomplishments, we most certainly must view with alarm many serious, unsolved health problems, some of which are presented in this report. These problems are cause for concern to every thinking Kentuckian. If we are to progress and maintain our right to be proud Kentuckians, we must press a concerted attack against our outstanding health problems. We must recognize that we, the people, are the State's greatest resource and that the promotion of good health is fundamental to conservation of that resource.

PHILIP E. BLACKERBY.

NOVEMBER 30, 1945.

Tuberculosis

Kentucky has the third highest tuberculosis death rate in the Nation.—About 1,800 Kentuckians die each year from this disease. While our death rate has been cut in half in the last 25 years, it is still 50 percent above the national average. Some 14,000 of us have active infections.

Tuberculosis is communicable.—Of the 14,000 estimated cases, three-fourths are not isolated and are therefore constantly spreading the infection among their families and other associates.

It is costly.—Most cases occur in low-income families. The victims are usually in the most productive period of life. When the disease strikes the wage earner in a low-income family, not only must care be provided for the patient, but financial assistance may be needed for his dependents. The indirect costs in terms of reduced earning power, broken homes, orphaned children, and relief burdens are great.

Not all tuberculosis has been found.—Of the 14,000 estimated cases in Kentucky, only 8,500 are known to health officers. This means that 5,500 persons have active tuberculosis and do not know it and are unwittingly exposing their families and friends to the disease.

Provisions for treatment are inadequate.—Sanatorium care is recognized as necessary for most patients and is usually the best means of isolating the infectious cases to prevent exposure of well persons. We have only 800 beds in this State for tuberculosis patients. Kentucky has fewer sanatorium beds in proportion to need than any State touching its borders. Furthermore, most of the beds now available are in Jefferson and Fayette Counties and are restricted to their residents. Fewer than 200 beds are available for the more than two million people in the rest of the State.

The present hospital construction program, when completed, will increase the number of available beds from the present 800 to more than 1,500. While this number is still below the standard recognized by tuberculosis authorities, it will be sufficient, if the hospitals are adequately maintained and operated, to effect great improvement in the tuberculosis control program.

There are few adequately staffed and equipped clinics available in Kentucky for case-finding and follow-up procedures.

The program for rehabilitation of arrested cases is very limited.

Sanitation

Filth-borne diseases kill 800 Kentuckians and cause the illness of 14,000 others in an average year.—Although the death rate for typhoid fever has been reduced from 26 to less than 2 per hundred thousand persons, the rate is still too high and only five States have more deaths than Kentucky. Diarrheaenteritis is a leading cause of infant deaths. Food poisoning causes many serious illnesses every year. Our death rate from dysentery is twice the rate for the Nation as a whole. One-fifth of us harbor intestinal parasites, such as hookworms or roundworms. These and other filth-borne diseases are part of the price we pay for our failure to practice personal hygiene and community sanitation.

Here are some plain facts about sanitation in our State:

Three hundred and thirty-three communities with populations from 200 to 3,000 have no public water supplies. Water from springs, unprotected wells, and cisterns is frequently unsafe. Two-thirds of our schools do not have safe water.

Though there are many communities with public sewers, few treat sewage in any way whatever before it is dumped into streams and sinkholes. The water drawn from wells or springs downstream is frequently polluted with sewage dumped upstream. Streams in and bordering the State are our chief source of public water supplies; because of their heavy pollution, water drawn therefrom requires expensive purification treatment before it is safe for human consumption.

One-half the State's population is served by open privies. These attract flies which then pollute food and milk.

Almost all garbage is untreated and fed to hogs or placed in uncontrolled fly- and rat-infested dumps. Hogs fed on raw garbage may contact trichinosis, a parasite disease, transmitted to man by means of incompletely cooked pork.

Four-fifths of the farm and rural population is inadequately protected from flies and mosquitoes, which carry disease germs.

Two-thirds of the total milk consumed in Kentucky homes is not pasteurized, and 45 counties have no pasteurized milk available. Relatively few dairies are above doubt as to cleanliness. Milk and cream brought to cheese plants and creameries are often filthy. Though milk is probably our most nearly complete food, it is potentially a dangerous carrier of disease unless clean and pasteurized.

Few commercial slaughter houses, meat packing, or chicken-killing plants have either Federal or local veterinary inspection; thus a large proportion of our population receives meat which may have come from questionable sources.

One-half of our population is served daily in the 4,000 Kentucky eating and drinking establishments. The average sanitation grade of these establishments is 50 percent.

Sanitation can be achieved and filth-borne diseases controlled only when Kentuckians realize that sanitation is more a mattter of public recognition and demand than of legislation and enforcement.

Cancer

One out of every 300 Kentuckians has cancer.—Some 2,500 die each year from this disease, which ranks third among the leading causes of death in the State.

Cancer is deceptive.—Of the estimated 10,000 persons in Kentucky who have the disease, not more than 4,000 know they do. The other 6,000 do not know they have cancer and most of them will seek medical care too late for cure to be effected.

Yet cancer can be controlled.—A high percentage of the cases can be cured if they are found early and receive prompt, modern, scientific treatment. The diagnosis and treatment of cancer require highly specialized techniques, which may be prohibitively expensive for a considerable number of victims.

Kentucky needs more case-finding and treatment facilities.—Although six cancer clinics for the medically indigent have been established through joint action of the field army of the American Cancer Society, the State medical association, and the State board of health, the number is too small. Personnel and facilities are available in these clinics for examining only about 600 persons a year.

The number of hospital beds available for treatment of medically indigent cancer cases is negligible. There are no homes for incurable cases.

Mental health

Six Kentuckians per day are admitted to our four State institutions for the mentally ill or mentally deficient. There are over 7,000 persons being cared for daily in these institutions. One-ninth of all Kentucky men examined for military service in World War II were rejected because of mental ill health or mental deficiency. Many other selectees later broke down under the stress of military life.

Mental hygiene assistance is not available to most Kentuckians, although it is estimated that 1 out of every 10 persons at some time during his life has a mental illness to a degree that some mental hygiene assistance should be obtained. Facilities for the guidance of either children or adults are very limited. Teachers receive little mental hygiene training.

Mental illness is officially considered a crime in Kentucky.—Most admissions to mental hospitals are through trial and commitment by criminal courts; only a few are voluntary. Too many Kentuckians consider mental illness a disgrace rather than a disease.

Incidentally, the law allows $1 per day for food for each inmate of a county jail, but only 57 cents per patient is available at our largest mental hospital for food, laundry, medical care, and all other services.

Our mental hospitals are overcrowded, often with patients who do not properly belong there. It is estimated that one out of eight patients in our mental hospitals is not mentally ill but is old, crippled, or unable to care for himself. Local courts commit such persons to mental hospitals because there seems to be no other way to care for them.

Fifty thousand Kentuckians are so mentally deficient as to need supervision, it is conservatively estimated. Possibly 5,000 of these require care in an institution. At present 2,000 of these defectives are in the custody of relatives or friends. Even if we assume that these 2,000 are well cared for, there still remain 3,000 defectives needing institutional care. Actually we have facilities for only 750 in the Feeble Minded Institute. By the most liberal estimate, therefore, Kentucky is meeting only about 25 percent of its responsibility for the feeble-minded, many of whom, given proper care and training, could become self-supporting.

Kentucky's pauper-idiot law has many undesirable features. It allows a maximum of only $75 per year to a person having the custody of an idiot. This stipend is inadequate to provide care and training, yet the total of these allowances would be sufficient to meet a good part of the cost of proper care and training in an institution. Further, since each pauper-idiot must be so adjudged every 5 years by local courts, there is great variation in the interpretation of the law and opportunity for abuse of its intent.

Venereal diseases

Some 100,000 Kentuckians have syphilis.—This disease is a great disabler and killer. One out of every eight persons admitted to Kentucky hospitals for the insane is there because of syphilis. More than one-tenth of all deaths due to diseases of the heart and blood vessels have this infection as their basic cause.

Annually at least 50,000 Kentuckians contract gonorrhea, the most common venereal disease. It is exceeded in prevalence only by measles and bad colds. This disease may cause crippling arthritis and many other conditions, such as sterility in women and blindness in infants.

Venereal diseases are spread chiefly through promiscuity.—Their control will be achieved when all cases in a communicable stage can be found and brought promptly under treatment and when communities take a dynamic role in the improvement of social conditions which encourage promiscuity.

Diseases of later life

Heart diseases, cerebral hemorrhage, and nephritis are leading causes of death in Kentucky. Combined they account for two-fifths of the deaths from all causes. Nearly three-fourths of these deaths occur in persons over 60 years of age. These diseases have become leading causes of death in comparatively recent years and the trend of their death rates is generally upward.

The control of the diseases of later life depends upon their early recognition so that the individual may be informed of his handicaps and can learn to live with them. These handicaps may be found through periodic health examinations. Few Kentuckians receive such examinations.

Dental health

Too many Kentuckians have dental defects.—Seven out of 10 school children in Kentucky need some kind of dental care. More men were rejected because of dental defects than for any other single cause in the early selective-service program of World War II. The high incidence of dental disease among the entire population is generally recognized.

There are too few dentists.—It has been said that there should be at least 1 dentist for each 2,000 persons for even minimal care. Actually Kentucky has only 1 dentist for every 4,000 persons.

Dentists are poorly distributed.—In 1940 6 counties had no dentists and 29 had only 1 each. They tend to locate in larger centers. Thus there are only 2,000 persons per dentist in counties with first- and second-class cities, while there are nearly 6,400 persons per dentist in rural areas.

Industrial health

Kentucky is becoming increasingly industrialized.—There were over 260,000 industrial workers in the State, according to the 1940 census, and many others attracted to war industries are expected to remain the same or similar occupations. Many serious industrial health hazards, such as those involving exposure of workers to inclement weather, exist in certain Kentucky industries; the accident, disease, and death rates from these causes are too high.

The average industrial worker loses from 7 to 10 working days per year, less than 10 percent of which, however, is due to industrial injury or occupational diseases. The remaining lost time is due to ordinary illness or other nonindustrial causes, a larg part of which could be averted by adequate medical and nursing service.

Yet 80 percent of the industrially employed in Kentucky are without inplant medical or nursing service.—The worst working conditions are usually found in the smaller plants, which are least able to develop their own health programs. It is apparent that these small plants should be helped to develop such programs, when it is realized that in Kentucky 95 percent of the industrial workers are employed by firms with less than 100 employees.

Physical defects

Too many Kentuckians have uncorrected physical defects.—More than one-fourth of all Kentucky men examined by Selective Service in World War II were rejected because of physical defects alone. The number rejected for this cause is greater than the total population of any city in Kentucky except Louisville. A National Youth Administration survey in 1941 showed one youth in three had physical defects that limited his employability.

Ten thousand crippled children are known to the Kentucky Crippled Children Commission, a large proportion of whom are not receiving care because of lack of funds. State and county health departments have found that out of each 10 school children examined, 3 have eye, ear, nose, or throat defects, 7 have dental defects, and 7 have poor posture or other defects.

While many corrections are being made annually, the achievements thus far represent hardly a good beginning.

Maternal and child health

For every 1,000 babies born alive in Kentucky 4 mothers die in childbirth.—Of these 1,000 babies, 60 die before their first birthday; of these 60, more than half die in their first month. Although the Kentucky death rates for mothers, infants, and preschool children are decreasing, they are still higher than the national average. To these figures must be added those of invalid mothers and sickly children, which also result, in great measure, from lack of good health supervision and medical care.

The number of these deaths and illnesses can be reduced. From one-half to two-thirds of maternal deaths are preventable by adequate medical supervision during pregnancy and the lying-in period. However, nearly one-fifth of Kentucky mothers do not have a physician at childbirth, and only one-sixth of the total births occur in hospitals.

Regular health supervision of infants and preschool children is effective in reducing the number of deaths and illnesses. Yet the majority of Kentucky's babies receive no health supervision whatever.

The maternal and infant death rates are still too high, though reductions have occurred. If further reductions are to be obtained, adequate medical care must be made more readily available to all. We cannot permit one-fifth of our mothers to go through childbirth assisted only by ignorant "granny women."

Nutrition

There is malnourishment in Kentucky.—The few surveys that have been made do not provide comprehensive, up-to-date information as to the extent and degree of that malnourishment. Good food habits are important in the development of healthy babies, the prevention of certain physical defects, and the maintenance of good health for everyone.

A State-wide nutrition survey is needed.—With the specific facts thus made available it would then be possible for all the various agencies concerned with the problems of nutrition to develop a coordinated plan of action to meet the needs found to exist.

Medical care

Adequate medical care is not available to all Kentuckians.—An important cause is the fact that personnel and facilities for medical care are inequitably distributed throughout the State. In counties with cities of the first and second class, there are only 650 persons per doctor while in rural areas there are more than 2,300 persons per doctor. It is recognized that physicians in the larger urban centers, particularly specialists, serve many persons outside their own counties, but even when allowances are made for this fact, we still find that the number of persons per doctor is much greater in rural areas.

Not only does the rural doctor have more patients dependent upon him but he is on the average older than the urban doctor, and is, therefore, physically unable to carry as heavy a load as the latter. Such factors as poor roads and lack of hospitals further limit the number of patients the rural physician can care for. These factors also influence the availability of dentists, nurses, pharmacists, and other types of technical personnel so essential in the provision of adequate medical care.

Professional personnel and facilities for medical care tend to be distributed in accordance with ability to pay rather than according to medical need.—Thus in counties with first- and second-class cities where the annual purchasing power is approximately $900 per person, there is 1 doctor to 650 persons, whereas in rural areas with an average of only $200 per person, there is only 1 doctor to more than 2,300. A similar situation prevails in regard to the distribution of dentists, nurses, pharmacists, and hospital facilities. In addition it is a well-known fact that those in the lower-income groups have higher sickness rates than those with better incomes, and therefore need more medical care per person although they are less able to pay for it.

The scarcity of hospital and allied facilities and the frequent lack of good roads, good schools, satisfactory churches, and recreational facilities make rural life unattractive to many professional persons seeking locations in which to establish practice.

Paying for medical care would still remain a problem even if sufficient professional personnel and facilities for adequate care were equitably distributed. Persons with large incomes are financially able to purchase needed medical care under almost any circumstances. Those with moderate to low incomes have little if any difficulty in meeting the expenses of relatively minor illnesses but find it difficult or impossible to meet the expenses incurred when catastrophic illness strikes. For this group some sort of prepayment plan is indicated. Most persons probably fall within this group. The medically indigent are, by definition, unable to pay for their own care and must have it provided for them by society, probably through taxation, if they are to receive it.

Improvement in the manner of paying for medical care is considered basic to its proper distribution. Enlightened citizens and the professions are not unaware of this problem and the challenge it presents. The Kentucky Medical Association has a committee with lay representation exploring the possibility of a prepayment medical care plan. Whether the costs of medical care should best be borne by taxation, by prepayment, by pay-roll deduction, or by some combination of these methods and others, is a matter yet to be determined.

A careful, detailed State-wide survey is needed to determine the scope of the problems of medical care and to evaluate the economic resources and capacities of the various communities to provide such care. The results of this survey should then be used as the basis for the development of a definite plan of action to meet the manifest needs.

Public health organization

Prevention of disease has been the primary concern of public health. It attempts to solve the common health problems of groups of people through such measures as sanitation, control of communicable diseases and the promotion of good health through educational processes.

Full-time health departments locally sponsored and locally operated are the recognized agencies for rendering local public-health services. Since Jefferson County organized the first full-time county health department in the United States in 1908, Kentucky has ranked among the leading States in the development of local public-health organizations. Of our 120 counties, 104 now have provisions for full-time public-health service.

But this is not as good as would appear on the surface. Sixteen Kentucky counties do not have health departments. Even among the 104 counties which have provided such organizations, the majority have thus far been able to provide only skeleton services because of limited personnel and facilities. For example, there should be a minimum of 1 public-health nurse for each 5,000 people; we have only 1 nurse to more than 10,000 people.

Public-health authorities have said that in normal times a minimal annual expenditure of $1 per person is necessary to maintain a local health department. Kentucky spends approximately 48 cents per person for this purpose.

Inability to pay salaries comparable with those paid by other States and agencies causes the loss of the majority of our more capable public-health personnel. For example, we annually train 10 new county health officers and lose 7 largely because of inadequate salaries.

Conclusion

It is apparent from this report that the diseases and defects to which our flesh is heir cause untold suffering. But these diseases and defects are not acts of providence; they are in large part the result of our own indifference as a people. We can improve the health status of Kentucky by the intelligent application of the remarkable discoveries which medical and public-health scientists have made and are making. On a scale never before equaled we have fought a world battle to be free. In a like manner we must fight and win the battle against unnecessary disease and death.

A PLAN OF ACTION BASED ON THE REPORT ON HEALTH MADE FOR THE COMMITTEE FOR KENTUCKY BY P. E. BLACKERBY, M. D., STATE HEALTH COMMISSIONER

(By O. O. Miller, M. D., immediate past president, Kentucky State Medical Association)

If we are to solve our outstanding health problems, it is essential that we, the people, take the following actions:

Tuberculosis

1. Complete the tuberculosis hospital construction program at once.
2. Provide adequate financial support for the maintenance and operation of the tuberculosis hospitals.
3. Provide a sufficient number of free hospital beds for all tuberculosis patients economically unable to furnish their own care.
4. Establish an dmaintain out-patient tuberculosis clinics in county and district hospitals and in various health-department centers for case finding and follow-up work.
5. Encourage premarital X-ray examinations of the chest.

Sanitation

1. Provide for each community and each home and school, urban or rural, a safe water supply, a satisfactory sewage-disposal system, and the proper disposal of garbage and other waste.
2. Secure adequate screening against flies and mosquitoes.
3. Pasteurize all milk sold to the public.
4. Provide for the periodic examination and X-ray of food handlers.
5. Make available sufficient sanitary supervision of all public food supplies and all food-handling establishments.
6. Eliminate pollution of streams.

Cancer

1. Expand greatly clinics and other facilities for finding cancer cases early.
2. Make provision for the proper treatment of all cancer cases promptly, emphasizing especially the need for hospital facilities for the victims in the low-income group.
3. Provide nursing homes for incurable cancer cases.

Mental health

1. Establish mental health clinics and foster mental hygiene.
2. Insist on adequate financial support for our State institutions for the mentally ill and mentally defective.
3. Review and modernize our laws pertaining to the mentally ill and mentally defective.

Venereal diseases

1. Endeavor to find all infected persons and bring them under treatment promptly.
2. Control promiscuity.

Diseases of later life

1. Provide a physical fitness program to encompass mental hygiene, recreation, moderation, and the intelligent use of leisure.
2. Stress enjoyment to be found in the home.
3. Establish facilities for periodic health examinations which should envisage the above.

Dental health

1. Expand facilities for children's dentistry.
2. Train more dentists and secure their equitable distribution.
3. Promote the extension of dental hygiene services.

Industrial health

1. Secure the establishment of good health program in all industrial groups.
2. Provide adequate locker and sanitary facilities for personal hygiene.
3. Make all health hazards compensable.
4. Eliminate conditions and operations which are contributory to ill health.
5. Encourage periodic health examinations of all employees.
6. Promote the training of physicians and other personnel in industrial hygiene.

Physical defects

1. Make available to every local area facilities for prevention and correction of physical defects.
2. Expand services for care of crippled children.

Maternal and child health

1. Provide an adequate number of hospital beds for maternity case in each local area.
2. Make prenatal care available to all mothers.
3. Encourage child spacing for invalid mothers.

Nutrition

1. Conduct county-by-county nutrition survey to secure the facts on which to base a coordinated nutrition program.
2. Promote nutrition education with emphasis on home production and conservation of food.
3. Extend research to determine effect of type of soil upon nutritional value of food.

Medical care

1. Make a thorough survey to obtain the facts on which to base a plan for improved medical care.
2. Provide scholarships for training men to practice in rural areas.
3. Make adequate hospital facilities available to all communities.
4. Provide special hospitals or nursing homes for the chronically ill.
5. Improve roads to facilitate better medical care.
6. Local taxation to provide medical care for the medically indigent with free choice of physicians, dentists, pharmacists, and nurses.
7. Encourage the development of prepaid medical-care insurance.
8. Cooperate immediately with the educational program and attack the causes of ill health at their source, namely, inadequate rural-school buildings, inadequate lighting, inadequate safe water supply, inadequate diet, inadequate recreation facilities, provide good libraries in each rural school as a first step in mental hygiene, and begin the physical-fitness program now.

Public-health organization

1. Establish full-time health units in every county and provide for their adequate financial support.

COMMITTEE FOR KENTUCKY

Officers

President: Harry W. Schacter, representing business, president, Kaufman-Straus Co., chairman, Louisville Municipal Housing Commission, chairman of the board, Kentucky Merchants Association.

First vice president: H. Fred Willkie, representing industry, vice president, Joseph E. Seagram & Sons, chairman, Governor Willis' Postwar Advisory Planning Commission.

Second vice president, Joe Betts, representing agriculture, director of information, Kentucky Farm Bureau Federation.

Third vice president, Dr. R. B. Atwood, representing Negro education, president, Kentucky State College.

Secretary, E. M. Josey, representing trade associations, secretary, Kentucky Pharmaceutical Association.

Treasurer, Edw. H. Weyler, representing Labor (A. F. of L.), secretary-treasurer, Kentucy State Federation of Labor.

Directors

Paul Blazer, representing industry, chairman, Ashland Oil Refining Co.

Dr. John W. Brooker, director of public relations, Kentucky Education Association.

Lee Coulson, representing radio, executive manager, Station WHAS.

John J. Cronin, representing social welfare, dean, Kent School of Social Work, University of Louisville.

Dr. Carl M. Gambill, representing health, director, division of county health work, Kentucky State Department of Health.

Mrs. Robert E. Johnson, representing women's organizations, president, Kentucky Federation of Women's Clubs.

Lt. Col. Albert H. Near, representing the armed forces, director of airports, Louisville and Jefferson County; veteran of World Wars I and II.

F. L. Stanley, representing Negroes, publisher and general manager, Louisville Defender.

Tom Wallace, representing the press, editor, Louisville Times, vice president, Inter-American Press Association.

Al Whitehouse, representing Labor (CIO), president, Kentucky State CIO Council.

Executive director: Maurice D. Bement.

Mailing address: 527 South Fourth Avenue, Louisville 2, Ky.

Senator DONNELL. This report will be made part of the record, and the committee will recess until 9:30 tomorrow morning in this room.

(Whereupon, at 5:10 p. m., the subcommittee adjourned until 9:30 a. m., Friday, June 27, 1947.)

NATIONAL HEALTH PROGRAM

FRIDAY, JUNE 27, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith, chairman of the subcommittee, presiding.

Present: Senators Smith (presiding), Donnell, and Pepper.

Senator Smith. The committee will come to order, please.

This morning we have five witnesses and I just want to say to the witnesses that there is a very important session of the Senate that will come on at 12 o'clock and I am very anxious to hear all the witnesses, but I want them to be as brief as they can be, filing their statements if necessary to fill in the gaps, because both Senator Donnell and I will be needed on the floor at noon today.

Before we begin this hearing I am going to file for the record the statement of Dr. A. W. Bailey, of Schenectady, N. Y., chairman of Committee on Health Insurance, American Osteopathic Association. If there is no objection that will be incorporated in the record.

(The statement referred to follows:)

Statement of Dr. A. W. Bailey, of Schenectady, N. Y., Chairman of Committee on Health Insurance, American Osteopathic Association, Before Senate Committee on Labor and Public Welfare on the National Health Act of 1947, S. 545

There are some 11,000 legally licensed osteopathic physicians or surgeons and in excess of 300 osteopathic hospitals in the United States. An annual average of 400 graduate from the 6 recognized schools of osteopathy and surgery, each graduate having had a minimum of 2 years training in an accredited liberal arts college prior to admission to the 4-year course in an osteopathic college. Fifty-eight intern-training hospitals are approved after annual inspection by the American Osteopathic Association.

Physicians training in osteopathic institutions are legally licensed and practicing in all the States. They take their places as general practitioners, specialists, as members of State boards of health, as county, city, and town health officers, and as industrial plant physicians and school physicians.

Manifestly, the osteopathic profession and institutions are interested in S. 545 which sets up a national health agency and institutes Federal-State systems for medical and hospital aid for families and individuals having insufficient income to pay the whole cost of hospital services, surgical services, and medical services.

A very considerable percentage of the population in each and all of the States look to the osteopathic profession and institutions for health services. Many patients of doctors of osteopathy are also patients of doctors of medicine and vice versa. That freedom of choice or change of physician or hospital must be preserved in any workable system of Government assistance.

S. 545 demands a billion dollars in Federal taxes from the pockets of the taxpayers. In their pockets they were free to spend it for any doctors or hospitals of their choice. If and when it is returned to them in their times of adversity, as proposed in this bill, it should be returned to them under safeguards protecting that freedom of choice. The idea that beggars cannot be choosers should have no place anywhere in the design or administration of plans for financial aid in obtaining medical or hospital care.

S. 545 is silent on this most important principle of preservation of choice of licensed physician and hospital. The preamble of the bill assumes to state certain policies of the United States. We suggest that an additional clause be included in the declaration of policy set forth in section 2 (c) of the preamble, so that it will read:

"That it is the policy of the United States to aid the States through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status, having full regard for the preservation of the right of the individual to choice of available physician or hospital."

We have some suggestions to make with regard to title 1 which creates a national health agency. It is our understanding that such an agency would not be considered in the event S. 140, which establishes a department of health, education, and security, is enacted into law.

The National Health Agency as proposed in S. 545 appears to emphasize and necessitate administrative more than medical ability. The duties include among other things the collection of health statistics, the administration of grants-in-aid, the prevention of water pollution, the purification of food and drugs and the administration of the Hospital Survey and Construction Act. A doctor of medicine might have obtained administrative training in addition to his medical training. So also might a doctor of osteopathy. If Congress deems it of paramount importance that the Administrator be a physician, we suggest that the words "doctor of medicine" on line 14, page 3, be deleted, and the word "physician" be inserted in lieu thereof, in order not to foreclose the eligibility of physicians other than doctors of medicine.

The words "and medicine," page 3, line 20, should be deleted as redundant.

Section 104 (c), page 9, line 14, requires that the Director of the Office of Medical and Hospital Care Services shall be a doctor of medicine. We suggest that the word "physician" be substituted for the words "doctor of medicine," in order not to foreclose the eligibility of physicians other than doctors of medicine.

Section 104 (d) establishes an advisory council on maternal and child care. We suggest that the first sentence on page 10 be amended to read as follows: "Such council shall be composed of nine members, at least four of whom, shall be doctors of medicine and one of whom shall be a doctor of osteopathy who are specialists in obstetrics or pediatrics."

Osteopathic physicians and surgeons are certified as specialists in obstetrics and pediatrics by the respective American osteopathic specialty boards recognized by the American Osteopathic Association, and inasmuch as the osteopathic profession is engaged in rendering maternal and child-health services, it is fitting and just that osteopathic representation on this Advisory Council on Maternal and Child Care be expressly provided for.

This is a national advisory council which would render advice on Federal policies involving maternal and child health programs. The Children's Bureau, which would be assigned to the National Health Agency under this bill, has for a number of years established and relied on the advice of extra-legal advisory committees on maternal and child health. Although the osteopathic profession has applied to the Children's Bureau on a number of occasions for representation on these advisory committees, no osteopathic representative has ever been appointed. The result has been that policies adopted by the Children's Bureau have been and are inimical to the patients and the practitioners of the osteopathic school of medicine. A flagrant example is the EMIC pediatric program in which the Children's Bureau has established a policy which expressly prevents the States from expending Federal funds for furnishing medical care to the infants of servicemen unless the physician chosen to render the service is a doctor of medicine. The patient must have a doctor of medicine, or forego the Federal assistance. The State must confine participation to doctors of medicine, or else have no program.

Passing now to title 2, which adds to the Public Health Service Act a title 7 entitled, "General Medical Service For Families and Individuals With Low Incomes", we have two amendments to suggest.

Section 712 (a) (4) requires that a State plan shall set forth a State-wide program designed and calculated to provide within 5 years hospital services, surgical services and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such; and periodic physical examinations for all children in elementary and secondary schools in the State. At the option of the State, medical care services may be furnished in one or more of the following ways: In institutions, in the home, or in physicians' offices. The State program may "also" provide for furnishing such services by full or partial payment of premiums or reimbursements to medical or hospital funds. The fact that the State program may also adopt the method of premium or reimbursement payments to such funds apparently means that such method may not be established as the exclusive method. If there is any doubt in that connection, it should be clearly stated that no person shall be obligated to subscribe to a health, medical, or hospital insurance fund in order to qualify for aid under the State program.

In connection with the permission granted to the States under section 712 (a) (4) to use Federal money for payments to voluntary health, medical, or hospital insurance funds, or other funds, operated not for profit, not only should any such private funds be required to be voluntary and nonprofit, their subscribers should have free choice of available physicians or hospitals.

For that purpose, we suggest that page 18, line 22, be amended by inserting after the word "profit," the words "the subscribers to which are permitted free choice of available physicians or hospitals."

This amendment is consistent with the amendment we have suggested to the preable of the bil and obtains for the same reasons.

Our second amendment to title 2 relates to the constitution of the National Medical Care Council established under section 715 (b). We suggest that the second sentence in section 715 (b) be amended to read as follows: "Six of the nine appointed members shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine and one of whom shall be a doctor of osteopathy." The amendment would make it necessary to substitute the word "nine" for the word "eight" in line 22, page 24. This amendment guarantees that the osteopathic profession and institutions shall have a voice in the program at the national level.

RECAPITULATION OF PROPOSED AMENDMENTS

Page 2, line 16, after the word "status", insert "having full regard for the preservation of the right of the individual to choice of available physicians or hospitals;"

Page 3, line 14, substitute "physician" for the words "doctor of medicine."

Page 3, line 20, strike the words "and medicine."

Page 9, line 14, substitute "physician" for the words "doctor of medicine."

Page 10, revise the first sentence to read: "Such council shall be composed of nine members, at least four of whom shall be doctors of medicine and one of whom shall be a doctor of osteopathy who are specialists in obstetrics or pediatrics."

Page 18, line 22, after the word "profit," insert "the subscribers to which are permitted free choice of available physicians or hospitals."

Page 24, line 22, substitute the word "nine" for the word "eight."

Page 24, revise the sentence beginning on line 22 to read: "Six of the nine appointed members shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine and one of whom shall be a doctor of osteopathy."

Senator SMITH. The first witness this morning is Mr. Patrick Tompkins, commissioner of the Massachusetts Department of Public Welfare, of Boston.

STATEMENT OF PATRICK TOMPKINS, CHAIRMAN, COMMITTEE ON MEDICAL CARE, AMERICAN PUBLIC WELFARE ASSOCIATION

Senator SMITH. Before you begin your statement, Mr. Tompkins, unless it is incorporated in the written statement, will you just give us a little biography of your background, experience, and your qualifications in this field?

Mr. TOMPKINS. I am 41 years of age, sir.

Senator SMITH. I did not mean to ask you for that, but we will be glad to know it. You look about 25.

Mr. TOMPKINS. I am a college graduate. I am starting my twentieth year in the field of social work and fifteenth in the field of public-welfare administration, which includes the direction of all programs in the small cities and large urban county.

I was assistant director for 7 years of the New York Department of State Public Welfare, and following Army service I was appointed not quite 2 years ago as commissioner of public welfare for the Commonwealth of Massachusetts.

Senator SMITH. That covers the whole State?

Mr. TOMPKINS. Yes, sir.

Senator SMITH. All right, sir; I think that gives us a little picture of your situation. Now, if you will go ahead with your report.

Mr. TOMPKINS. I would like to say first, sir, that my organization is grateful for the opportunity to file this statement, and if the committee has no objections, I would like to read it to them.

Senator SMITH. I am trying, if I can, to keep the witnesses to about 15 or 20 minutes this morning. I think probably you can cover it in that time. There may be one or two questions we will want to ask you, but go ahead on your own line, Mr. Tompkins.

Mr. TOMPKINS. My name is Patrick Tompkins. I am commissioner of the Massachusetts Department of Public Welfare and appear today in my capacity as chairman of the medical-care committee of the American Public Welfare Association, the organization of State and local public-welfare departments and of public-welfare officials, board members, and workers throughout the country. Affiliated with the association are the National Council of State Public Assistance and Welfare Administrators and the National Council of Local Public Welfare Administrators.

My testimony today is directed toward S. 545, the National Health Act of 1947, which has been the subject of study by our medical-care committee. I am not authorized to testify on S. 1320, the National Health Insurance and Public Health Act of 1947, as this measure has not received official consideration by our group. I would like to say, however, that in my own view the two measures are not actually comparable and should not be considered in terms of alternatives. Health insurance, like other forms of social insurance, is essentially a form of compulsory saving designed to prevent rather than deal with the fact of need. From an administrative and policy point of view, S. 1320 does not constitute a public-welfare measure as we define our own field. While we public-welfare administrators are, of course, actively interested in all measures to reduce the need for the services we administer, our particular experience and competence does not include the administration of insurance programs.

S. 545 is, on the other hand, essentially a welfare measure and is, therefore, a proposal to which we can bring a useful experience. The fact that this bill deals with a particular area of human need, namely need for medical care, and therefore involves relationship to the medical and related health professions, in no way lessens the fact it is also a welfare measure which should be scrutinized in the light of long-established principles and policies designed to protect both the taxpayer and the recipient in public welfare programs.

The fact also that S. 545 provides for the administration of medical care for the needy through a National Health Agency and through the State health departments does not remove it from the category of welfare measures. Any program designed to deal with a deficit in the family budget on the basis of an individual determination of need, whether that need is for medical care, food, or complete maintenance is essentially a welfare program. Most States now make some provision for medical care for the needy through welfare departments, both by including provision for medical need in the federally aided assistance grants to the aged, blind, and dependent children and through the use of their State and local welfare funds for other needy groups. We welcome, however, the broadening interest of health departments in the medical-care field and recognize a trend toward an increasing assumption of administrative responsibility, frequently in cooperation with welfare departments, in this area of service. The same principles will apply regardless of the agency administering the program.

These principles derive from the peculiarly delicate reconciliation of public and private interests inherent in public welfare programs. Welfare programs are inevitably costly involving as they do the supplementation of family budgets. In many States the welfare department has the largest budget of any State agency. At the same time they touch on the most personal aspects of family life. The job of a welfare administrator is primarily concerned with finding the means simultaneously of protecting the taxpayer's dollar through sound administrative practice and protecting the recipient through sound social-work practice. He is the channel between the taxpayer, legislators, budget officers, and others who must supply the necessary funds to finance these costly programs and the professional social workers who spend them in the interests of the needy of the State. It is not an easy task, I can assure you, and the administrator would be helpless without a legislative framework which recognizes both factors. Under the Social Security Act, which is extremely specific in these respects, we have accumulated a considerable body of experience on Federal-State relationships in this area.

On the basis of this experience we are obliged to conclude that S. 545 lacks the necessary minimum provisions to protect either the taxpayer or the recipient and would place the administering State agency in an extremely difficult position. At the same time we recognize the great need for additional Federal aid to the States for medical care for the needy and feel, on the basis of our experience, that legislation could be devised which would protect the medical practitioner and others furnishing service from governmental interference in professional questions without sacrifice of the public interest.

The specific difficulties which we would foresee in the administration of S. 545 arise from a confusion of the roles of administrator and practitioner and an apparent fear that any standards or minimum requirements would constitute interference with the rights of the latter.

The bill itself sets no standards and specifically prohibits the Federal Director from doing so. This is virtually unprecedented in Federal grant-in-aid programs. It makes no provision for merit system standards of personnel. It includes none of the safeguards for the individual recipient that characterize the assistance program such as the requirement that case records be treated as confidential, that the benefits of the program be available in all political subdivisions of the State, and that the individual be accorded the right of a fair hearing.

The bill permits public funds to be turned over to nongovernmental agencies for expenditure with no controls either as to standards of service or accountability of funds. This, too, is unprecedented and represents a major departure from our views of sound public welfare policy. We, of course, recognize the desirability of purchasing service on a requisition basis for individual cases from private physicians and institutions but feel that to turn over public funds in lump-sum amounts for unspecified purposes as is apparently permissible under this bill provides no protection either of public funds or of the recipient. This is no criticism of the medical profession, the administrators of medical institutions, or the management of private health insurance plans. It is rather a question of public policy and sound administrative practice.

The bill gives to an advisory council composed of nine persons five of whom must be doctors of medicine the right to over-rule the decision of the administrator on the approval of State plans. The confusion here of administrative and professional questions is most apparent. State plan approval involves not only decisions of policy in the public interest but also legal questions of conformity to the Federal law. Such decisions should be made only by those whose sole accountability is to the public, either as administrators or in the Federal courts. A comparable practice in public assistance would permit appeal of decisions of the Social Security Administrator to a board a majority of whom would have to be professional social workers.

The designated composition of the advisory councils at both Federal and State levels makes provision only for those groups who are in the role of suppliers of the service which this bill proposes to finance and none for those who represent the interest of the public or the recipient. It has always been the practice in appointing persons to State and local boards of public welfare to consider their role as representative of the public rather than a specialized professional interest, and we feel that this principle should be recognized here through adequate representation of all groups.

The financing provisions of S. 545 would not, in our opinions, meet the needs in all parts of the country since the requirement for the States to match Federal funds on a dollar-for-dollar basis does not take account of the inequalities of fiscal ability among the States. Our experience with grants-in-aid on this basis has demonstrated that the States in greatest need often receive the least in Federal aid because of their inability to put up the necessary State funds on an even matching basis. Last year the assistance provisions of the Social Security Act were amended to provide a larger Federal share of the lower payments to individuals. For example, in old-age assistance the Federal Government now puts up $10 of the first $15 paid to a needy old person. This has resulted in a substantial increase in the Federal percentage of payments in the lower income States. We in our association are committed to the principle that Federal aid to the States and State aid to its political subdivisions in the welfare field should take into account the equalization principle in order to assure more nearly equitable treatment to individuals in similar circumstances. This involves two basic principles: a Federal law which provides the basis for a common national program even while retaining the advantages of State and local administration and the use of Federal resources to equalize inequities among the States. S. 545 would appear to lack both of these elements.

Should a bill specifically directed toward providing medical care for the needy outside the assistance program become law, and we are not opposed to this on principle, the relationship between the two programs would have to be very carefully worked out. Most States now meet the medical needs of the needy aged, blind, and dependent children under the assistance program; and in certain types of care, such as nursing home care for example, it is almost impossible to differentiate between maintenance and medical care. On the other hand, assistance is regarded as a "residual" function, and the Federal law requires that all resources available to the individual be taken into account in making this grant. The questions therefore of what should be charged to each program, which agency should certify need, how adjustments of the family budget should be made and related questions would have to be carefully worked out in each State on the basis of conditions in that State. There are a number of ways in which the provisions of S. 545 would complicate or hinder this adjustment process.

In the first place we would hope that Congress would not decide to separate the administration of health and welfare functions at the Federal level as proposed in this bill. We favor the elevation of the Federal Security Agency to the Cabinet level in a combined Department of Health, Education, and Security as proposed in the Aiken bill, S. 712. Since Federal functions in these fields, unlike those at the State and local level, are not operational but involve rather planning, policy formulation, and the administration of grants-in-aid to the States, we feel that there is every advantage in keeping them in one over-all department in order to facilitate the working out of these delicate, evolutionary interrelationships.

At the State level, while we recognize the trend toward increasing health-department responsibility, we feel that the great variations among the States make it desirable to leave the designation of the administering agency to State determination. The present requirement that health-department administration be achieved "on or before 1949" would not seem to give adequate time for working out the transfer in many States, takes no account of the special agencies already operating in other States, such as the North Carolina Medical Care Commission, or the States where related health functions are now outside health departments and gives no latitude to those States which feel they would wish to continue their present administrative arrangements.

The third and most serious difficulty which I foresee under S. 545 in working out the relationship of this to other welfare programs grows out of the fact that there is no consistent Federal policy between the two. Should a comprehensive federally aided welfare program such as that incorporated in S. 1355, recently introduced by Senator Cooper and now pending in the Senate Finance Committee, which covers the recommendations of our association for Social Security Act liberalization be adopted this difficulty would be greatly aggravated. Even under present legislation the differing matching requirements might create a competitive relationship between the two programs and the departure of S. 545 from the long-established principles which we feel should govern welfare programs would create not only confusion but a dangerous precedent for all other welfare programs. If, for example, it is acceptable Federal policy to turn public funds for medical care for the needy over in lump sum to private health agencies why not turn over assistance money to private charitable agencies? Yet we in public welfare have been formally committed to the principle that public welfare funds should be spent through public agencies for many years and this principle was incorporated in the Social Security Act. We in public welfare adhere to the principle that welfare administration should be removed from politics by a merit-system requirement. Yet if this requirement is to be removed in one welfare program how is it to be maintained in the others? For this reason we feel that should a separate bill for grants to the States for medical care for the needy be enacted it should contain requirements both with respect to financing and administration which are consistent with the rest of Federal welfare policy as incorporated in the Social Security Act.

There is no question in our minds regarding the need for extended Federal aid to meet the residual needs of those who are unable to maintain an acceptable minimum standard of life consistent with American concepts of health and decency and no question that this standard must include provision for medical care. We feel that the sponsors of this measure are to be congratulated for recognizing the problem but hope that the administrative-end-policy aspects of this bill will undergo extensive revision to meet the objection I have raised if it is to be recommended to the Senate for enactment.

Senator Smith. Thank you very much, Mr. Tompkins.

I gathered in your statement on the second or third page, I don't know which it was, that you advocated an equalization principle; that is, recognizing the principle of national standing of different States. That, of course, it seems to me is incorporated in this bill, but maybe we haven't worked out the right kind of formula. We are attempting it now. We had the same thing in our educational bill. We are trying to work out the same principle.

Have you any different plan than the one that is offered here?

Mr. Tompkins. Nothing specific; no, sir.

Senator Smith. How did it happen that you seem to fail to recognize that we are meeting that?

Mr. Tompkins. I think the provision that I was referring to was that the State has to put up as many dollars for the operation of the program as were contributed by the Federal Government, so that it would be put on the even-up matching basis as our committee reviewed the bill.

Senator Smith. In the formula here we recognize the difference in the standing of the States, and so forth. That is a matter, of course, that will be studied further.

I do not feel personally committed to any particular formula because we are definitely of a mind to recognize the differences in wealth, and so forth, among the various States, and where the greatest need is for Federal aid, as we tried to do in our educational bill.

I notice also here, Mr. Tompkins, your criticism of not setting down standards, apparently, and yet toward the end you seem to imply that the States can handle their own program.

I take it that a State like Massachusetts, from all the evidence we have here, is exceptionally well organized and I can well understand when you have a State like Massachusetts that the best help we can give you is to give you our blessing and say, "Go ahead, here is a grant-in-aid, if your State needs a grant-in-aid for the development of your own program."

We want the States to have the same responsibility to work out their own health programs without being too closely confined by Federal rules. We do not think we can blueprint the plans here in Washington but we think we can help make contributions to them.

Mr. Tompkins. I think our organization is in complete accord with the statement you made but I would merely add to it there are certain basic principles of administration that should be established by the Federal agency no matter what division it may be, whether the National Health Agency or Federal Security Agency, and a principle such as a merit system and the insistence on extension of this program to all of the people of the State rather than to only selected areas of the State, dependent upon whether it would be State administered or locally administered with State supervision.

Senator Smith. Well, maybe we have progressed far enough in this sort of an administrative set-up to know where we are going and maybe we can lay down those rules Nation-wide now. My own feeling is that we have to proceed on evolutionary ground.

That is the theory of this bill, that we have a very large leeway and we hope as time goes on to have your State, perhaps, get suggestions from my State, New Jersey, or vice versa, or from some Western State that is found to be most practicable from the standpoint of administration. We are groping for light rather than to have the light before we begin.

I don't think it is perfect by any means. You say it is unprecedented, but I think it is perfectly justified to have the Federal Government now take the attitude of mind of giving aid where it is needed, and we want the States to tell us how to meet these problems and put in the bill the main things that should be met, namely, taking care of medical care for people in the lower income groups and school children. We may go further than that but we want to start in a small way and grow, rather than start in a big way and find out later this and that kind of thing does not work.

Mr. Tompkins. I would repeat, of course, that the principle of State determination of methods that are to be employed in administering any plan of welfare, which this bill in essence is, is to determine the need for medical care.

However, all States should be required to meet certain minimum principles of management, or specifications. Certainly there should be some requirement in the use of medical institutions that those medical institutions meet certain minimum standards with respect to the kind of medical care that they are expected to provide.

Senator Smith. What do you mean by "medical institutions"? You speak here on page 7 of "private health agencies." Do you mean by that a private hospital or do you mean by that the Blue Cross people?

Mr. TOMPKINS. No; I refer largely to your large incorporated hospitals, some of which are operated by religious groups, some of which are financed by community groups or community chests.

Senator SMITH. Are we wise enough now to lay down the rules under which they should proceed, or should we find out and ask them to submit their plans? We are simply trying to encourage the best possible development.

Mr. TOMPKINS. I think your health administrator on a national level would be wise enough on the basis of his experience and competence to establish certain minimum standards with respect to physicians and their standards of service, whether it be medical institutions or otherwise, as to the quality of medical service that is to be provided.

Senator SMITH. Then you are prepared today to ask the Federal Government to lay down code rules?

Mr. TOMPKINS. Not necessarily. A set of principles probably.

Senator SMITH. I have tried to think through those principles and how they would develop and what would happen. I would not have any hesitation to recommend that the State of Massachusetts, with its well-organized set-up, would be entitled to its pro rata share of these funds and give them our blessing and say, "We know you can use them better than we can tell you how to use them."

I agree with you that there are certain very minimum standards but the whole question then would be one of how far you are going to say, "This is the rule and this is the rule," with the danger that somebody might be complying with the spirit of the thing and yet might not quite make the letter of the rule and he would be disqualified.

I think there is always the danger in it when you get too specific, but that is my view. You were in a way approaching the problem from the standpoint of administration.

I am grateful to you. Senator Donnell, do you have any questions?

Senator DONNELL. No.

Senator SMITH. Senator Pepper, have you some questions?

Senator PEPPER. Mr. Tompkins, you say this bill does require a means test, as you understand it?

Mr. TOMPKINS. Yes, sir.

Senator PEPPER. Do you think it is necessary, Mr. Tompkins, out of your experience as commissioner of the Massachusetts Department of Public Welfare and chairman of the committee on medical care, American Public Welfare Association, that we provide a great improvement in the volume or a great increase in the volume of medical care of all kinds now, I mean beyond what is now available to the American people?

Mr. TOMPKINS. Yes; I am positive of that, sir.

Senator PEPPER. You are convinced that the present system does not meet the needs of the American people?

Mr. TOMPKINS. Yes; I am.

Senator PEPPER. And that it is imperative in the interest of humanity that we go ahead from where we are?

Mr. TOMPKINS. That is correct; I think in the last paragraph I made mention of that in my statement.

Senator PEPPER. Well, now, Mr. Tompkins, will this bill which contemplates an appropriation of $200,000,000 to be matched by certain State funds in your opinion meet the medical needs of the people of this country?

Mr. TOMPKINS. I don't think, Senator, that I am competent to answer that precisely. It is unfortunate that in our welfare programs there has been to date no research which has been able to isolate the cost and identify it. As you are probably aware, the three Federal agencies require that the grant to the recipient be given in cash on the basis of an unrestricted lump-sum payment, which makes it virtually impossible without some research to identify the amount of money that has actually been paid out for medical care.

We have completed a 6-month study in the Commonwealth of 19 selected communities of varying sizes, which unfortunately we have not been able to tabulate the results of. We hope to have that before the summer is over, but I do not believe that our committee would be competent to say that $200,000,000 matched by the States, or the States and the political subdivisions of the States, would be adequate or excessive at this point. We do know that there is a need for an extension of Federal agencies to meet the present enormous needs of the people for medical care.

Senator PEPPER. Well, Mr. Tompkins, you recognize, do you not, the difference between the indigent, of the actual normally indigent and the medically indigent?

Mr. TOMPKINS. That is correct.

Senator PEPPER. And the medically indigent is a very large class in the country?

Mr. TOMPKINS. Yes.

Senator PEPPER. And if you were to provide by State and Federal appropriations for meeting the medical needs of all medically indigent as well as the actually indigent it would probably require a very large sum of money, wouldn't it?

Mr. TOMPKINS. Very substantial sums; yes, sir.

Senator PEPPER. Now, one other thing. Have you found it to be a matter of some difficulty to lay down a means test which can be applied to all of the people generally without difficulty and embarrassment?

Mr. TOMPKINS. There is a considerable area of difficulty because of the different approaches by the local and State administrators and differences between local administrators. Then inversely as the population base of the community grows smaller.

We have tried to put into effect a rule that the person in need of medical care, whose normal other needs are met by his income or personal resources, should not be expected to be able to pay for medical care, either of short or of long duration, by his actual income whatsoever, which gives him a welfare budget of at least 15 percent.

Senator PEPPER. What is the welfare budget?

Mr. TOMPKINS. Well, the welfare budget is merely a cost-of-living minimum schedule of consumption items such as rent, fuel, and light.

Senator PEPPER. How much is that in terms of dollars per year?

Mr. TOMPKINS. In our State at the present time for an aged person, old-age recipient, a male, who lives alone and has absolutely no other income and assuming a $25-a-month payment of rent, he would get $72 per month.

Senator PEPPER. I know, but what annual gross income do you regard as necessary for a decent standard of subsistence for an American family of four?

Mr. TOMPKINS. That is a question which must call for a relative answer, because the cost of living has fluctuated so substantially in the last few years. Our present relief recipient budget for an ABC family of four would run at about $135 a month. That is purely from memory. I am pretty confident that is fairly close to accurate.

Senator PEPPER. Does that include any budget for medical care?

Mr. TOMPKINS. Medical care which is supplied at $1.25 per month per person.

Senator PEPPER. Does that contemplate the family laying aside any money?

Mr. TOMPKINS. No, it does not. We further provide medical care and nursing services over and above that.

Senator PEPPER. When you say $135 a month, whatever medical care would be required would be over and above that?

Mr. TOMPKINS. That is right.

Senator PEPPER. A very large segment of our population today comes below that income level, doesn't it?

Mr. TOMPKINS. Yes.

Senator PEPPER. So that if you are going to appropriate the money to give the needed care to all that class it would require a considerable Federal appropriation, would it not?

Mr. TOMPKINS. It certainly would.

Senator PEPPER. Well, thank you very much, Mr. Tompkins.

Senator SMITH. Thank you very much, Mr. Tompkins.

The next witness is Dr. Reginald M. Atwater of the American Public Health Association of New York.

STATEMENT OF DR. REGINALD M. ATWATER, EXECUTIVE SECRETARY, AMERICAN PUBLIC HEALTH ASSOCIATION

Senator SMITH. Unless your statement gives us your biography, will you not for the record just indicate a history of your background and experience?

Dr. ATWATER. My name is Reginald M. Atwater. I am a physician, a graduate of the Harvard Medical School and of the Johns Hopkins University. I am licensed to practice medicine in Massachusetts and New York. I am executive secretary of the American Public Health Association.

Senator SMITH. I think that is all right. Will you give us your statement? There is a statement by you consisting of some 15 pages, the statement you are presenting.

Dr. ATWATER. I can summarize it in about 10 minutes, sir.

Senator SMITH. That is what I am wanting, but I am wondering if you would like to have it incorporated in the record?

Dr. ATWATER. Yes.

Senator SMITH. We will put the entire brief in the record at this point and you may supplement it with your statement.

(The brief referred to follows:)

TESTIMONY SUBMITTED ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON SENATE BILL 545 BY REGINALD M. ATWATER, M. D., EXECUTIVE SECRETARY, BY DIRECTION OF THE EXECUTIVE BOARD

Senate bill 545 is concerned with the basic problem of assuring adequate medical care to the American people. It is also concerned with the organization of the health services of the Federal Government and would, if enacted, exert an important influence on the structure and functions of public health administration. It would seem proper, therefore, that the most careful consideration be given to the provisions of this bill in order to determine whether it meets the urgent health needs of our population and whether the proposed reorganization is administratively sound.

THE PUBLIC HEALTH PROFESSIONS ARE CONCERNED

The American Public Health Association, as the professional organization of health workers, is deeply interested in both these problems. This interest was expressed in an official statement of association policy, "Medical Care in a National Health Program," which was adopted at the 1944 annual meeting. We should like to comment on Senate bill 545 from the standpoint of this policy statement, a copy of which is included as Appendix A.

This official statement recognized that "A large portion of the population receives insufficient and inadequate medical care, chiefly because persons are unable to pay the costs of services on an individual payment basis when they are needed, or because the services are not available." Numerous studies have documented the truth of this observation. The committee on the costs of medical care, which was headed by Dr. Ray Lyman Wilbur, found in 1928–31 that the lack of adequate medical care was not confined to the very lowest-income groups but extended throughout all or most of the population. While professional standards called for approximately 5½ physician's calls per person per year, only those with an income of $10,000 or more attained this standard. Persons in families with incomes between $5,000 and $10,000 had 4 physician calls per person; between $3,000 and $5,000, only 3 physician calls; and below $3,000, only two to two and one-half physician calls. Similar inadequacies were discovered in regard to general hospital care, dental care, immunizations, laboratory services, and refractions and glasses.[1]

Studies made in 1941 indicate some of the economic factors responsible for these inadequacies. In that year, families and single consumers with an income of $5,000 and over spent an average of $310 for medical care; those with incomes of $3,000–$5,000 spent $151; the $2,000–$3,000 income group spent $105; and those with incomes below $2,000 spent an average of $53 for medical care.[2]

HOW MANY AMERICANS CAN AFFORD MEDICAL CARE?

In 1939, the Bureau of Medical Economics of the American Medical Association reached the conclusion that families with incomes of less than $3,000 sometimes require outside assistance in the case of major illness, while those with incomes below $1,500 may need special assistance even for minor illnesses.[3] These data gain added significance when it is recalled that even in 1941, when the per capita income reached its highest pre-war peak, 51 percent of American families and single consumers had annual incomes of less than $1,500, and 85 percent had annual incomes below $3,000.[2]

DO MOST AMERICANS RECEIVE ADEQUATE MEDICAL CARE?

It is true that there has been a substantial increase in money incomes during the war years. Nevertheless, the Federal Reserve Board reported that in 1945, at the peak of wartime prosperity, 47 percent of all families and single consumers had total annual incomes of less than $2,000, 70 percent had incomes of less than

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[1] (Medical Care for the American People—Committee on the Costs of Medical Care, No. 28, University of Chicago Press, 1932, p. 8.

[2] (Spending and Saving of the Nation's Families in Wartime) U. S. Department of Labor, Bull. No. 723, 1942, p. 2, p. 18.

[3] Factual Data on Medical Economics, Bureau of Medical Economics, American Medical Association, Chicago, 1939, p. 66.

$3,000, and 92 percent had incomes of less than $5,000.[4] Moreover, there has been a very substantial increase in the cost of living and the tax burden, so that real incomes have not changed nearly as much as the statistics for money incomes would appear to indicate. In addition, the costs of medical care have risen considerably, both because of scientific developments which have continued to make adequate medical care more expensive, and the general rise in costs of services which has increased the cost of hospital care, for example, to unprecedented heights. We may therefore conclude that the statement that a majority of the population does not receive adequate medical care is certainly as true today as it was before the war.

MEDICAL COSTS ARE UNEVEN AND UNPREDICTABLE

A major reason that inability to pay for medical care is not limited to the very lowest-income groups lies in the uneven distribution of medical costs. In 1941, for example, among farm families with annual incomes of $750 to $1,000, 37 percent spent less than $25 for medical care, while 18 percent of the families spent anywhere from $100 to $500.[5] This uneven distribution holds true for all income groups. It is no comfort to the individual family to know that the average cost of medical care is 4 percent of income. If a family with an annual income of $3,000 lays aside 4 percent or $120 for medical costs, it may spend $10 or it may have to spend $1,000. To the individual family, medical costs are entirely unpredictable and often cause a crushing financial burden. There are few of us indeed who from personal resources can meet the medical costs of a disease such as cancer, or of a serious accident, with care lasting over a period of months and requiring the services of skilled specialists. That is why a national program of medical care must be oriented toward meeting the needs of the entire population, not merely the very low income groups. It is essential also that the program does not result in two separate systems of medical care, one for the poor and another for the well-to-do. For these reasons our association declared that "A national program for medical care should make available to the entire population all essential preventive, diagnostic, and curative services."

S. 545 IS INADEQUATE

Unfortunately, S. 545 does not meet this criterion of a national program for medical care. It is designed primarily to provide Federal aid to the States for the medical and dental care of the needy. The bill states explicitly that the services are for "families and individuals with low income" (p. 16, 1. 18) who are "unable to pay the whole cost of such services" (p. 18, 1. 23). Implicit in this language is the application of a means test to determine those whose incomes are sufficiently low to be eligible. In actual practice, only recipients of public assistance and those who are one step removed from public assistance could receive benefits under this bill.

The average American citizen has a deep abhorrence of the means test and of private and public charity. He will prefer to go deeply into debt, do without or dangerously delay needed medical services rather than submit to a financial investigation and accept charity medical care. This is a very important factor which will operate to limit the effectiveness of the proposed legislation.

A BILL OF VERY LIMITED SCOPE

Finally, the size of the Federal appropriation is such as to make it impossible to pay the medical costs for more than a small fraction of the population. Before the war, the people of the United States spent approximately $4,000,000,000 for all forms of medical service. A conservative estimate of the total cost today would be at least $5,000,000,000. Those familiar with the skyrocketing costs of hospital care, for example, will agree that this estimate is a most cautious one. S. 545 provides for a maximum of $200,000,000 in Federal grants to the States. While it provides that the State appropriations shall be equal to the Federal grants, there is no requirement that the matching funds be new funds. In the absence of such a requirement, it may be expected that in most States the matching funds will be those already being expended. If new funds are expended by the States to the amount of $50,000,000, the total new funds provided by S. 545 would equal $250,000,000. Since the estimated total cost for the entire population is at least $5,000,000,000, one may draw the conclusion that the new funds provided by S. 545 would be sufficient to care for only about 5 percent of the population. We may expect that the available funds would be further curtailed by the expensive as well as cumbersome administrative machinery which will be necessary to administer the means test.

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[4] (Federal Reserve Bulletin, August 1946, p. 851.)

[5] What Farm Families Spend for Medical Care, U. S. Department of Agriculture Misc. Pub. No. 561, April 1945, p. 9.

The scope of the hospital, surgical, and medical services provided by S. 545 is nowhere defined, while the States are given the option of providing such services "in one or more of the following ways: In institutions, in the home, or in physicians' offices" (p. 18, l. 13). It is therefore possible for States to furnish services in hospitals only, with no provision for home or office care or for supplementary home nursing care, laboratory and diagnostic services, or prescribed medicines and appliances. That this may be the rule rather than the exception is indicated by the provision allowing payment of premiums to voluntary plans. It is well known that in most States voluntary plans are limited to hospitalization and surgical and obstetrical care in the hospital. There is nothing in S. 545 to prevent a State from paying premiums to a voluntary plan that provides only hospital care instead of discharging its full responsibilities to the needy by furnishing adequate and comprehensive care in the home, office, and hospital.

For these reasons, the American Public Health Association does not consider that Senate bill 545 meets its definition of an adequate national health program. We realize that Congress may not be prepared to legislate a complete program at this time, and should like to suggest, therefore, that serious consideration be given to other programs which will satisfy some of our most urgent health needs. This was the procedure adopted by Congress when it passed the Hospital Survey and Construction Act last year.

PREFERABLE PLANS

One of the first steps which needs to be taken is the expansion of comprehensive preventive services to the entire population. A careful study by the subcommittee on local health units of our association, published in 1945, showed that approximately 40,000,000 citizens of the United States still live in communities lacking full time local public health services. In 10 States with a population of nearly 10,000,000 persons, less than 25 percent of the total population is served by full time local health officers.

The minimum ratio for public health nursing service, including school nursing but not bedside care of the sick, is 1 nurse to 5,000 population. This minimum is met in only 3 States, while in 20 States the ratio of public health nurses to population is 1 to 10,000 or more. There are similarly gross shortages in the number of professionally trained sanitary personnel, laboratory workers, dental hygienists, and health educators (appendix B).

PREVENTIVE SERVICES FOR THE WHOLE POPULATION

That is why we declared in our statement of principles:

"It is imperative that the plan include and emphasize the provision of preventive services for the whole population. Such services include maternity and child hygiene, school health services, control of communicable diseases, special provisions for tuberculosis, venereal diseases, and other preventable diseases, laboratory diagnosis, nutrition, health education, vital records, and other accepted functions of public health agencies, which are now provided for a part of the population.

"The Federal and State Governments should provide increased grants for the extension of adequate public health organizations to all areas in all States. Increased Federal grants should be made conditional upon the requirement that public health services of at least a specified minimum content shall be available in all areas of the State."

NEEDLESS LOSS OF LIFE

Each year, 3,000 mothers die needlessly as a result of childbirth, while 31,000 babies who could have been saved die in their first year. The needs of the hundreds of thousands of children crippled by orthopedic impairments, rheumatic fever, cerebral palsy, sight and hearing defects, and other conditions are far from being met. We suggest substantial increases in Federal grants to the States for maternal and child health.

FUNDS FOR CANCER, HEART DISEASE, AND DIABETES

Public health services need to be expanded to include the control of those diseases which require extensive specialized care or represent serious national problems in terms of high morbidity and mortality. We approve, therefore, the appropriation of Federal funds for cancer control activities of the local and State governments as provided in S. 545. We suggest, however, that the sum of $10,000,000 now included for cancer control may not prove sufficient in future years and should therefore not be established as a ceiling on subsequent appropriations for this essential purpose. We recommend also that additional Federal funds be made available to the States for the control of heart disease, diabetes, and other chronic diseases which are today the major causes of disability and death in the United States. Early diagnosis and adequate treatment of these diseases are essential to offset their severe damage.

NEED FOR MORE MEDICAL EDUCATION

Another urgent need relates to medical education and research. Only recently the presidents of 19 American universities joined in a warning of the uncertain future of medical education, upon which medical care and public health are dependent. They declared that with present resources few if any of the 70 recognized medical schools in the United States can be confident of maintaining their programs at a high level in the future.[6] Their statement is particularly relevant in view of the serious shortage of physicians and other trained medical personnel.

Federal grants-in-aid for medical education and research can play an important role in increasing our scientific knowledge of the prevention, control, and treatment of those diseases before which we are powerless today. It will assist our medical schools to maintain and improve the quality of medical education, and can stimulate the development of postgraduate medical education, a field which has been relatively neglected in the past. Finally, it can help the medical schools to become focal points in raising standards of medical practice through such means as the development of regional consultation services. It is suggested that these aims will be better fulfilled, and the more wise and efficient use of public funds secured, if those responsible for making such grants-in-aid are assisted by competent professional advisory bodies.

STRENGTHEN THE HOSPITAL CONSTRUCTION PROGRAM

Finally, we suggest that Congress consider strengthening the hospital construction program by improving the formula for allocation of Federal funds and providing funds for operation and maintenance in the areas of greatest need. At present Federal funds are limited to one-third the costs of construction. This limitation works a serious hardship on the poorer communities which need the facilities most. It may defeat the purpose of the program which was designed primarily to assist rural communities to construct badly needed hospitals and public health facilities. An allocation formula which would grant a higher percentage of construction costs to communities in the poorer States, together with Federal aid for maintenance and operation, are essential to meet the urgent needs for hospital construction.

S. 545 IN DETAIL

We should like now to comment on the details of S. 545 and particularly on the administrative structure which is proposed.

Title I creates a National Health Agency as an independent agency without Cabinet department status. The American Public Health Association is already on record as favoring the establishment of a Cabinet Department of Health, Education, and Security by converting the Federal Security Agency into such a department. This is the proposal made in Senate bill 712, which we support.

We believe the Department of Health, Education, and Security to be preferable to a Cabinet Department of Health at this time. There are numerous areas in which the interests of health, education, and security interlock, and in which close coordination is necessary. Examples which demonstrate the need for such coordination include the care of crippled children, school health services, vocational rehabilitation, and the program of medical care for the needy contemplated in S. 545. We consider therefore that to set up an independent health agency without Cabinet department status, as is proposed in this bill, would not be in the best interests of the Nation's health.

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[6] New York Times, March 16, 1947.

VAGUE QUALIFICATIONS VERSUS ADMINISTRATIVE COMPETENCE

The Director of the Office of Medical and Hospital Care Services is required by the bill only to have at least 5 years of active medical practice and to be "outstanding in the field of medicine," and the Director of the Office of Dental Care Services is required to be a doctor of dental surgery with at least 10 years of active practice and to be "outstanding in the field of dentistry." We consider that such experience is seriously inadequate. These positions require years of training and experience in medical and public health administration, subjects not taught in medical schools and rarely included in the experience of private practitioners.

Although the stated purposes of S. 545 include the phrase "to expand the activities of the Public Health Service," the organizational scheme which is outlined for the National Health Agency actually reduces the Public Health Service to a subordinate position as one of seven or more constituent units. This fact, together with the requirements set by the bill for the National Health Administrator, lead to the conviction that S. 545 might result in the health services of the Federal Government being administered by a physician unqualified in public health and administration who will have a position of authority over such highly qualified medical and public health administrators as the Surgeon General of the Public Health Service.

LINKING UP PREVENTIVE AND CURATIVE MEDICINE

Moreover, we consider it very important to achieve a maximum integration of preventive and therapeutic medicine. This is the pattern followed today, with the Public Health Service responsible for grants-in-aid for preventive health services as well as the hospital survey and construction program. S. 545 establishes a separate Office of Medical and Hospital Care Services headed by a physician who is not required to be trained in public health or medical administration. There is a definite risk that this will result in a lack of coordination between preventive and therapeutic services and a failure to place that primary emphasis on prevention of disease and promotion of health which should be the cornerstone of all medical services.

THE PROPOSED SET-UP IS UNDESIRABLE

The American Public Health Association is therefore opposed to the administrative structure outlined in S. 545. We suggest instead that the Federal Security Agency be given the status of a Cabinet department as provided in Senate bill 712, and that responsibility for additional medical-care programs belong properly in existing health agencies. We believe that the existing agencies have carried out their responsibilities with a high degree of professional competence and devotion and see no reason for carrying through a reorganization which would tend to impair their effectiveness.

A SINGLE STATE AGENCY

Title VII of S. 545 provides general medical service for families and individuals with low income. It states that a single State agency must be designated to administer this service and that on or before 1949 such agency shall be the State health agency (p. 17, line 7 ff.). This administrative pattern, so far as it goes, is approved by the association as consistent with our policy statement, which reads:

"A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public-health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future."

The composition of the State medical and hospital care advisory councils is defined in S. 545 to include "representatives of State medical associations, State hospital associations, voluntary nonprofit prepaid medical-care plans and voluntary nonprofit prepaid hospital plans, or other groups interested in the improvement of medical and hospital services and in the better distribution thereof" (p. 17, line 12 ff.). In our opinion this definition should be expanded to include, specifically, representatives of farm, labor, and other consumer organizations in order to assure adequate representation of the point of view of the public.

THE PUBLIC INTEREST

Likewise, the National Medical Care Council is set up with the Director of the Office of Medical and Hospital Care Services as Chairman, and with eight members appointed by the Administrator of the National Health Agency. S. 545 specifies that "five of the eight appointed members shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine. The other three appointive members shall be persons familiar with the needs for medical and hospital care in urban or rural areas." It is obvious that there is insufficient representation of the public in the Council. Only three of the nine members represent consumer interest, while five of the nine, an absolute majority, are physicians. The Administrator, who is also a physician, is given the responsibility of making the appointments. It would appear logical that the public interest in the expenditure of public funds should receive more adequate representation.

UNSOUND PUBLIC POLICY

The power of the National Medical Care Council to overrule the decisions of the Director in regard to approval of State plans or modifications thereof (p. 20, line 21 ff.) is contrary to sound administrative practice. It is inappropriate to give this body of part-time representatives veto power over administrative officials who are charged with carrying out the purposes of the bill. The Council should remain an advisory body. Otherwise the administration of public funds will be controlled by persons who are not responsible to the public and whose main allegiance may well be to the organizations and interests they represent rather than to the public welfare.

STANDARDS ARE ESSENTIAL

Senate bill 545 fails to make any provisions for Federal or State standards in regard to methods of administration or quality of care. There is no requirement that the State plans define the methods of administration, including those relating to the establishment and maintenance of personnel standards on a merit basis. The failure to include such a requirement would permit inefficient administration of the programs by unqualified personnel. It would also make it possible to turn the de facto administration of State programs over to the voluntary prepayment plans with which the State is empowered to arrange for medical and hospital service (p. 18, line 15). In spite of the fact that some of these voluntary plans are very useful and that they operate in the public interest, in our opinion it overlooks the fundamental principle of public responsibility for the spending of public funds. The failure to require minimum State standards of administration, public responsibility, and quality of medical services provided under this bill gives insufficient protection to the public treasuries and to those receiving service.

It should be noted that S. 545 explicitly prevents Federal standards of any sort (p. 21, line 3):

"No plan or modification shall be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated by July 1, 1952, to provide hospital services, surgical services, medical services, and periodic physical examinations as required by section 712 (a) (4) at a cost within the probable financial resources of the State with Federal aid. It is intended that the State shall devise in each case the methods by which this end is attained."

We believe it to be manifest that Federal standards have played an important role in developing high-quality public-health services at the State and local levels. To prohibit Federal standards would set a precedent which could only result in administrative confusion and deterioration of quality of service. We believe that this provision of S. 545 is opposed to the best interests of local and State agencies and the health of the public they serve.

APPEAL BOARDS ARE ESSENTIAL

Among the requirements for State plans which should be specified in the bill is the establishment of appeal boards for both patients and physicians. There should also be provision for advisory councils, composed of representatives of consumer groups and providers of service, to function at the local level. These requirements are necessary to protect the interests of all concerned and to guarantee a maximum of local participation in the program.

Title VIII, which provides for dental health services for school children and families and individuals with low income, is generally similar to title VII. The criticisms which have been made of title VII in this statement apply equally to title VIII.

NATIONAL INSTITUTE OF DENTAL RESEARCH APPROVED

We approve the provisions of title IX establishing a National Institute of Dental Research in the National Institute of Health and granting Federal funds for research in dental health. Since the future needs for dental research cannot be foreseen at this time, we suggest that the proposed limitation of appropriations for this purpose to $600,000 in subsequent years be removed.

S. 545, AN INADEQUATE PROGRAM

In conclusion, the American Public Health Association does not consider S. 545 to represent an adequate national health program. We have suggested alternative programs for your consideration, such as expansion of comprehensive public-health services both in scope and content, Federal aid to medical education and research, and liberalization of Federal grants to provide needed hospital facilities. We believe the proposed reorganization of the Federal health services in S. 545 to be administratively unsound. The inadequate requirements for the administrators of the medical and dental care programs, the lack of sufficient consumer representation on advisory boards, the power given to national advisory councils to overrule decisions of the responsible administrators, the failure to require State plans to set minimum standards of administration and services, and the specific prohibition of all Federal standards lead to the conclusion that Senate bill 545 does not sufficiently protect the public interest in the expenditure of public funds for medical care.

APPENDIX A

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MEDICAL CARE IN A NATIONAL HEALTH PROGRAM—AN OFFICIAL STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, ADOPTED OCTOBER 4, 1944

At the annual meeting of the committee on administrative practice of the American Public Health Association, October 9, 1943, the committee directed its subcommittee on medical care to draft a set of principles expressing the desirable content of a comprehensive program of medical care, the methods of its administration, and the part which public-health agencies should take in its operation. In pursuit of this assignment, the subcommittee completed a tentative draft, which was considered and adopted by the committee on administrative practice at its meeting October 1, 1944. The report was then transmitted to the governing council of the association where, after certain revisions, it was adopted as a statement of association policy.

Because of its composition and charge, the subcommittee has limited its considerations to one sector of a comprehensive national-health program, namely, medical care.

In preparing the report, the subcommittee has considered—

A. The needs for a national program for medical care.
B. The objectives of such a program.
C. Recommendations for immediate action.

The American Public Health Association through its national organization and its constituent societies stands ready to collaborate with the various professional bodies and civic organizations which may be concerned with either the provision or receipt of medical service with a view to implementing the following general principles:

A. THE NEEDS

I. A large portion of the population receives insufficient and inadequate medical care, chiefly because persons are unable to pay the costs of services on an individual payment basis when they are needed, or because the services are not available.

II. There are extensive deficiencies in the physical facilities needed to provide reasonably adequate services. Such facilities include hospitals, health centers, and laboratories. The needs are most acute in poor communities, in rural areas, and in urban areas where the population has increased rapidly or where the development of facilities has been haphazard or the financial support inadequate.

III. There are extensive deficiencies in the number and the distribution of personnel needed to provide the services. Here again the needs vary according to categories of personnel and to characteristics of communities.

IV. There are extensive deficiencies in the number and categories of personnel qualified to administer facilities and services.

V. Many communities still are not served by public-health departments; others inadequately maintain such departments. Thus, some communities have never utilized organized health work to reduce the burden of illness, and others share its benefits only in part. In these communities especially, people lack information on the benefits of modern medical care.

VI. Expansion of scientific research is urgently needed. Despite past and current scientific advances, knowledge as to the prevention, control, or cure of many diseases is lacking.

Each of the six conditions defined above can be broken down into many component parts representing specific needs. In general, however, solutions of these broad problems require simultaneous attack on four fronts: namely, the distribution of costs, construction of facilities, training of personnel, and expansion of knowledge.

B. THE OBJECTIVES

I. A national program for medical care should make available to the entire population all essential preventive, diagnostic, and curative services.

II. Such a program should insure that the services provided be of the highest standard, and that they be rendered under conditions satisfactory both to the public and to the professions.

III. Such a program should include the constant evaluation of practices and the extension of scientific knowledge.

C. RECOMMENDATIONS

The recommendations presented in this report represent guides to the formulation of a policy for action. It is believed that study of these recommendations by the professions and others concerned in the States and localities will produce new and more specific recommendations for the attainment of the objectives of a national-health program.

Recommendation I. The services

(*a*) A national plan should aim to provide comprehensive services for all the people in all areas of the country. In light of present-day knowledge, the services should include hospital care, the services of physicians (general practitioners and specialists), supplementary laboratory and diagnostic services, nursing care, essential dental services, and prescribed medicines and appliances. These details of content must remain subject to alteration according to changes in knowledge, practices, and organization of services.

Because of inadequacies in personnel and facilities, this goal cannot be attained at once; but it should be attained within 10 years. At the outset, as many of the services as possible should be provided for the Nation as a whole, having regard for resources in personnel and facilities in local areas. The scope of service should then be extended as rapidly as possible, accelerated by provisions to insure the training of needed personnel, and the development of facilities and organization.

(*b*) It is imperative that the plan include and emphasize the provision of preventive services for the whole population. Such services include maternity and child hygiene, school health services, control of communicable diseases, special provisions for tuberculosis, venereal diseases, and other preventable diseases, laboratory diagnosis, nutrition, health education, vital records, and other accepted functions of public-health agencies, which are now provided for a part of the population.

(*c*) Insofar as may be consistent with the requirements of a national plan, States and communities should have wide latitude in adapting their services and methods of administration to local needs and conditions.

Recommendation II. Financing the services

(*a*) Services should be adequately and securely financed through social insurance supplemented by general taxation, or by general taxation alone. Financing through social insurance alone would result in the exclusion of certain economic groups and might possibly exclude certain occupational segments of the population.

(*b*) The services should be financed on a Nation-wide basis, in accordance with ability to pay, with Federal and State participation, and under conditions which will permit the Federal Government to equalize the burdens of cost among the States.

Recommendation III. Organization and administration of services

(*a*) A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public-health agencies Federal, State, and local—should carry major responsibilities in administering the health services of the future. Because of administrative experience, and accustomed responsibility for a public trust, they are uniquely fitted among public agencies to assume larger responsibilities and to discharge their duties to the public with integrity and skill. The existing public-health agencies, as now constituted, may not be ready and may not be suitably constituted and organized, in all cases, to assume all of the administrative tasks implicit in an expanded national health service. Public-health officials, however, should be planning to discharge these larger responsibilities, and should be training themselves and their staffs. This preparation should be undertaken now because, when the public comes to consider where administrative responsibilities shall be lodged, it will be influenced in large measure by the readiness for such duties displayed by public-health officers and by the initiative they have taken in fitting themselves for the task.

(*b*) The agency authorized to administer such a program should have the advice and counsel of a body representing the professions, other sources of services, and the recipients of services.

(*c*) Private practitioners in each local administrative area should be paid according to the method they prefer, i. e., fee-for-service, capitation, salary, or any combination of these. None of the methods is perfect; but attention is called to the fact that fee-for-service alone is not well adapted to a system of wide coverage.

(*d*) The principle of free choice should be preserved to the population and the professions.

(*e*) State departments of health and other health agencies are urged to initiate studies to determine the logical and practical administrative areas for a national medical care plan.

Recommendation IV. Physical facilities

(*a*) Preceding, or accompanying, the development of a plan to finance and administer services a program should be developed for the construction of needed hospitals, health centers, and related facilities, including modernization and expension of existing structures. This program, should be based on Federal aid to the States and allow for participation by voluntary as well as public agencies, with suitable controls to insure the economical and community-wide use of public funds. The desirability of combining hospital facilities with the housing of physicians' offices, clinics, and health departments should be stressed.

(*b*) Federal aid to the States should be given on a variable matching basis in accordance with the economic status of each State.

(*c*) Because of its record of experience and accomplishment in this field, the United States Public Health Service should administer the construction program at the Federal level, in cooperation with the Federal agencies responsible for health services and construction.

(d) Funds available under this program should be granted only if:

(1) The State administrative agency has surveyed the needs of the State for hospitals, health centers, and related facilities, and has drawn up a master

plan for the development of the needed facilities (taking account of facilities in adjacent States); or, in the absence of a State plan, the project is consistent with surveys of construction needs made by the United States Public Health Service;

(2) The proposed individual project is consistent with the master plan for the State; its architectural and engineering plans and specifications have been approved by the State agency and/or the United States Public Health Service; and there is reasonable assurance of support and maintenance of the project in accordance with adequate standards.

(*e*) State health departments are urged to conduct studies to develop State plans for the construction of needed hospitals, health centers, and related facilities. Such studies should be made in cooperation with official health agencies, with State hospital associations, and other groups having special knowledge or interests.

Recommendation V. Coordination and organization of official health agencies

(*a*) The activities of the multiple national, State, and local health agencies should be coordinated with the services provided by a national program. There is no functional or administrative justification for dividing human beings or illnesses into many categories to be dealt with by numerous independent administrations. It is difficult to reorganize agencies or to combine activities and this cannot be accomplished hurriedly. Therefore studies and conferences should be undertaken without delay at the Federal level, and in those States and communities where the health structure is already unnecessarily complex.

(*b*) The Federal and State governments should provide increased grants for the extension of adequate public-health organization to all areas in all States. Increased Federal grants should be made conditional upon the requirement that public-health services of at least a specified minimum content shall be available in all areas of the State.

Recommendation VI. Training and distribution of service personnel

(*a*) Within the resources of the program, financial provisions should be made to assist qualified professional and technical personnel in obtaining postgraduate education and training.

(*b*) The plan should provide for the study of more effective use of auxiliary personnel (such as dental hygienists, nursing aides, and technicians), and should furnish financial assistance for their training and utilization.

(*c*) Professional and financial stimuli should be devised to encourage physicians, dentists, nurses, and others to practice in rural areas. Plans to encourage the rational distribution of personnel, especially physicians, should be developed as quickly as possible, in view of the coming demobilization of the armed forces. Such plans should be integrated with the whole scheme of services and the establishment of more adequate physical facilities.

Recommendation VII. Education and training of administrative personnel

(*a*) Education and training of administrative personnel should be encouraged financially and technically, especially for those who may serve as administrators of the medical-care program, for hospital and health-center administrators, and for nursing supervisors.

(*b*) State health departments should utilize those funds that may be available to train personnel in such technics as administration of health and medical services, and hospitals. Such a training program may contribute more than any other single activity to the future role of the official public-health agency. As a corollary, the attention of schools of public health is directed to the importance of establishing the necessary training courses.

Recommendation VIII. Expansion of research

(*a*) Increased funds should be made available to the United States Public Health Service and to other agencies of Government (Federal, State, and local), and for grants-in-aid to nonprofit institutions for basic laboratory and clinical research and for administrative studies and demonstrations designed to improve the quality and lessen the cost of services.

(*b*) The research agencies and those responsible for making grants-in-aid should be assisted by competent professional advisory bodies to insure the wise and efficient use of public funds.

APPENDIX B

Population served by full-time local health officers; per capita expenditures for local health service; and ratios to population of Public Health nurses, sanitary workers, and clerical workers, by State and the District of Columbia, 1942[1]

MINIMUM REQUIREMENTS

1. Expenditure of $1 per capita for local health service.
2. One public health nurse per 5,000 population (including school nursing but not bedside care of the sick).
3. One sanitary worker per 25,000 population.
4. One clerk per 15,000 population.

Region and State	Percent of population served by local full-time health officers	Per capita expenditures for local health service	Public Health nurses per 5,000 population	Sanitary workers per 25,000 population	Clerical workers per 15,000 population
United States	66	$0.61	0.6	1.1	0.6
New England:					
Connecticut	77	.75	.9	.9	.5
Maine	24	.33	.4	.6	.3
Massachusetts	67	(2)	(2)	(2)	(2)
New Hampshire	43	.56	1.1	.5	.1
Rhode Island	40	.58	.6	.7	.6
Vermont	None	.58	.7	None	None
Middle Atlantic:					
New Jersey	53	1.10	1.1	2.1	1.1
New York	77	.99	.8	1.0	.9
Pennsylvania	70	.49	.5	.9	.3
South Atlantic:					
Delaware	58	.54	.8	.8	.3
District of Columbia	100	1.59	1.2	3.1	2.4
Florida	70	.63	.5	1.5	.7
Georgia	82	.52	.6	1.0	.5
Maryland	100	.71	.6	1.3	.8
North Carolina	92	.57	.5	.8	.9
South Carolina	100	.43	.5	1.0	.5
Virginia	72	.51	.4	1.2	.5
West Virginia	77	.33	.3	.6	.5
East North Central:					
Illinois	65	.53	.5	.8	.5
Indiana	12	.30	.4	.5	.2
Michigan	87	.68	.7	1.3	.8
Ohio	68	.58	.5	1.1	.5
Wisconsin	38	.54	.6	.7	.5
East South Central:					
Alabama	100	.49	.4	1.1	.6
Kentucky	90	.54	.6	1.1	.9
Mississippi	89	.57	.4	.9	.7
Tennessee	89	.64	.6	1.3	.8
West North Central:					
Iowa	6	.25	.3	.4	.1
Kansas	41	.27	.3	.5	.2
Minnesota	34	.42	.5	.6	.4
Missouri	54	.46	.4	1.1	.5
Nebraska	25	.33	.5	.6	.2
North Dakota	10	.24	.4	.2	.1
South Dakota	11	.28	.4	.04	.1
West South Central:					
Arkansas	87	.39	.4	.6	.7
Louisiana	93	.72	.6	2.0	1.0
Oklahoma	61	.32	.3	.6	.3
Texas	56	.40	.3	1.1	.4
Mountain:					
Arizona	68	.54	.8	.6	.3
Colorado	53	.58	.7	.9	.4
Idaho	21	.30	.5	.2	.3
Montana	32	.41	.6	.2	.2
Nevada	15	.60	1.1	.5	.3
New Mexico	100	.68	.7	.6	1.1
Utah	14	.67	.8	1.5	.6
Wyoming	13	.41	.6	8.3	.1
Pacific:					
California	93	.94	.6	2.2	.9
Oregon	87	.65	.7	1.1	.7
Washington	76	.65	.7	1.4	.4

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[1] Local Health Units for the Nation, H. Emerson and M. Luginbuhl, New York, the Commonwealth Fund, 1945, p. 16 ff.

[2] Not reported.

Dr. Atwater. The American Public Health Association represents public-health workers in North America—not only the physicians, but other workers as well. It is a comprehensive group 75 years old.

We are very much concerned with this bill, as our friends of public welfare are concerned with it, and we would like to examine this bill in the light of an officially adopted statement of principles of the association which is incorporated in our statement as appendix A.

Senator Donnell. Is that the one that was adopted on October 4, 1944.

Dr. Atwater. Yes; 1944.

Senator Smith. It is the printed statement attached to your mimeographed statement; is that right?

Dr. Atwater. That is right.

It must be realized that a large proportion of the population does receive insufficient and inadequate medical care, either because people are unable to pay the costs or because the services are not available.

We have documented that story going back to the study of the Committee on the Costs of Medical Care about 15 years ago. Those studies indicated that adequate medical service calls for approximately five physician's visits per patient per year and even in those days the only persons who got that level of service were those whose incomes exceeded $10,000.

The volume of medical care declines rapidly with declines in the income of individuals, so that below $3,000 income per annum only about half enough medical service is made available at the present time, according to the standards adopted by that very representative committee.

You gentlemen know that there are large sections of the population who cannot afford medical care. For example, in 1939 the Bureau of Medical Economics of the American Medical Association reached the conclusion that persons with incomes of less than $3,000 per annum sometimes required outside assistance for the major causes of illness, while those with incomes below $1,500 per annum need special assistance even for minor illnesses.

Well, now, even in 1941——

Senator Donnell. Pardon me, Doctor. What you are referring to is chart No. 39 of Factual Data on Medical Economics, Revised in 1940; is it not?

Dr. Atwater. I am referring to table V–2, page 296.

Senator Donnell. Of what year and of what publication?

Dr. Atwater. It is publication No. 22 of the Committee on Costs of Medical Care.

Senator Donnell. Of the American Medical Association?

Dr. Atwater. I beg your pardon. I was referring to the preceding one.

Senator Donnell. I am talking about your statement here. I say you were referring to action by the American Medical Association.

Dr. Atwater. I am referring to page 66 of the 1939 publication on Factual Data on Medical Economics.

Senator Donnell. That was revised in 1940. You are familiar with the revision; are you not, Doctor?

Dr. Atwater. I am not personally familiar with the revision.

Senator DONNELL. Well, I say it is the same table, chart 39. We have this table in the record. I want to be sure. I wish you would look at it, Doctor, for a moment and tell us whether you recognize it as the same one to which you refer?

Dr. ATWATER. It is essentially the same, sir.

Senator DONNELL. Yes. Thank you, Doctor.

Dr. ATWATER. Resuming, then, it appears in 1941, when the per capita income reached its highest prewar peak 51 percent of American families and single consumers had annual incomes of less than $1,500 and 85 percent of the population fell in the group below $3,000, so that it is a substantial part of the population that needs help.

You do not need to have me emphasize the fact that a majority of the population does not receive adequate medical care now. It certainly is as true today as it was before the war.

You are fully aware of the fact, I know, that medical costs are uneven and unpredictable. On the bottom of page 3 I have pointed out here that if a family with an annual income of $3,000 should lay aside, for instance, 4 percent for medical care, which happens to be a national average, it may spend $10 a year or may have to spend a thousand dollars a year.

To the individual family medical costs are entirely unpredictable and often cause a crushing financial burden. There are few of us indeed who can meet the full medical costs of a disease such as cancer. That is why we feel that a national program of medical care must be oriented toward meeting the needs of the entire population, not merely meeting the needs of the low-income groups, and we say that the program should not result in two separate systems of medical care, one for the poor and another for the well-to-do. So that we have declared for a national program for medical care that should make available to the entire population all essential preventive, diagnostic, and curative services.

We believe that Senate 545 is inadequate; it does not meet this criterion of a national program. It is designed primarily to provide Federal aid to the States for the medical and dental care of the needy.

Implicit in this language is the application of a means test to determine those whose incomes are sufficiently low to be eligible. In actual practice we believe only those in need of public assistance could receive the benefits of this bill.

We remind you of the abhorrence that the average American citizen has for the means test and of private and public charity. He prefers to go deeply into debt, to do without or dangerously delay needed medical services rather than submit to a financial investigation and accept charity medical care.

We point out that this Senate 545 is of very limited scope, and this answers a question which came up a little while ago.

Before the war the people of the United States spent approximately $4,000,000,000 for all forms of medical services. A conservative estimate of the total cost today would be at least $5,000,000,000 and those familiar with the skyrocketing costs of hospital care, for example, would agree that this estimate is a most cautious one.

Senate 545 provides for a maximum of $200,000,000 in Federal grants to the States. While it provides that the State appropriations shall be equal to the Federal grants, there is no requirement that the matching funds be new funds. In the absence of such a requirement, it may be expected that in most States the matching funds will be those already being expended. If new funds are expended by the States to the amount of $50,000,000, the total new funds provided by Senate 545 would equal $250,000,000, which is approximately the cost of 5 percent of the medical care in the United States and we may expect that these available funds would be further curtailed by the expensive and cumbersome machinery—administrative machinery which would be necessary to a determination of the means test.

We further point out that this bill does not define the scope of hospital, surgical, and medical services. It would be possible for States to furnish services in hospitals only, with no provision for home or office care or for supplementary home nursing care, and so forth.

That this may be the rule rather than the exception is indicated by the provision allowing payment of premiums to voluntary plans. It is well known that in most States these voluntary plans are limited to hospitalization and surgical and obstetrical care in the hospital. There is nothing in the bill to prevent a State from paying premiums to a voluntary plan which provides only hospital care, instead of fulfilling its whole responsibility to the needy.

So we do not consider Senate 545 as meeting our definition of an adequate national health program. We recognize that Congress may not be prepared to legislate a complete program at this time. We should like to suggest, therefore, that serious consideration should be given to other programs which will satisfy some of the more urgent health needs. That was what the Congress did last year when it passed the Hospital Survey and Construction Act.

Of these alternative plans, just let me name two. There are 40,000,000 of our citizens that still live in communities lacking full-time local public-health services. The number of persons that may have access to nursing service is very low. This results in preventive service to the general population being far below an acceptable standard, and we feel that increased Federal grants should be made conditional upon the requirement that at least a public-health service of a specified minimum content should be available in all areas of the State.

We point out that not less than 3,000 mothers die needlessly as a result of childbirth each year and that approximately 31 babies who could have been saved die in their first year.

We point out the large need of funds for cancer, heart disease, and diabetes. We point out the urgent need for more medical education.

Only recently the presidents of 19 American universities joined in a warning of the uncertain future of medical education, which is, of course, the foundation stone of medical care and public health.

We believe that Federal grants-in-aid for medical education and research can play a very important part.

We believe that the hospital-construction program needs to be strengthened in order that the number of communities which need the facilities most can get these facilities, which is not now the case.

Commenting on this Senate 545 in detail, we do not agree that in title I the creation of a National Health Agency without Cabinet status would be wise. We are on record as favoring the establishment of a Cabinet Department of Health, Education, and Security.

Senator PEPPER. May I interrupt you just a moment? I want to say to the committee and to the witnesses that I apologize for having to go immediately to another committee meeting.

I notice that Dr. Theodore Sanders, of the National Federation of Settlements, is here, and Mr. Edward J. Slater, secretary, Essex Trades Council of Newark. I believe each of you will testify in behalf of S. 1320; is that correct?

Well, I want to express to Dr. Atwater and to you two my regrets that I will not be able to hear your testimony, but I will read it, and if I can get back later in the morning I will. I appreciate your coming very much.

I thank you, Mr. Chairman.

Senator SMITH. Thank you, Senator Pepper.

Dr. ATWATER. The American Public Health Association has gone on record as favoring the establishment of a Cabinet Department of Health, Education, and Security, and we have supported Senate bill 712.

We believe that that would be distinctly preferable to a Cabinet Department of Health at this time for reasons as stated.

We believe that Senate 545 has exceedingly vague qualifications as to the leadership which would be there. It requires only 5 years of active medical practice and someone outstanding in the field of medicine. There is no requirement for administrative responsibility, which is another matter not taught in any medical school and acquired very rarely by physicians in general practice.

We feel that, although the stated purpose of Senate 545 includes the phrase, "to expand the activities of the Public Health Service," we think that the organizational scheme which is outlined for the National Health Agency actually reduces the Public Health Service to a subordinate position as one of seven or more constituent units.

This fact, together with the requirements stated in the bill for the National Health Administrator, leads to the conviction that this Senate 545 might result in the health services of the Federal Government being administered by a physician unqualified in public health and unqualified in administration, who will have a position of authority over such highly qualified persons as the Surgeon General of the Public Health Service.

Moreover, we think there should be a close link between the preventive and curative services provided by the Federal Government, and we do not think that the separate office of medical and hospital care services would contribute to this end.

We suggest that instead of this arrangement the Federal Security Agency should be given the status of a Cabinet department. We believe that the existing agencies in the Federal Security group have carried out their responsibilities with a high degree of professional competence and devotion. We see no reason for carrying through a reorganization which would tend to impair their effectiveness.

We have something to say relating to a single State agency. This administrative pattern, so far as it goes, is approved by the association. However, we believe that the other features, such as the representation on these advisory boards, are inadequate for the reasons stated.

We do not believe that it would be fair to make five of the eight appointed members of the National Medical Care Council physicians. The statement there is:

> Five of the eight appointed members shall be persons who are outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine.

We think there is an insufficient representation of the public in the Council. We believe that the power of the National Medical Care Council to overrule the decisions of the Director in regard to the approval of State plans or modifications thereof is contrary to sound administrative practice. It is inappropriate to give this body of part-time representatives veto power over administrative officials who are charged with carrying out the purposes of the bill. The Council, we think, should remain an advisory board. Otherwise the administration of public funds will be controlled perhaps by persons who are not responsible to the public and whose main allegiance may well be to the organizations and interests they represent rather than to the public welfare.

We agree with the American Public Welfare Association's testimony that standards are essential. We believe the failure to include a requirement for standards, such as merit system, would permit inefficient administration of the programs by unqualified personnel. It would make it possible as it stands to turn the de facto administration of State programs over to the voluntary prepayment plan with which the State is empowered to arrange for medical and hospital service.

In spite of the fact that some of these voluntary plans are very useful and they operate in the public interest, it is our opinion that the bill overlooks the fundamental principle of public responsibility for the spending of public funds.

We believe that appeal boards are essential. We approve the provision for a National Institute of Dental Research. But finally, gentlemen, the association does not consider Senate 545 to represent an adequate national health program.

We have suggested alternate programs for your consideration, such as expansion of comprehensive public health service both in scope and content, Federal aid to medical education and research, liberalization of Federal grants to provide needed hospital facilities.

We believe the proposed reorganization of the Federal health services in Senate 545 to be administratively unsound. The inadequate requirements for the administrators of the medical and dental-care programs, the lack of sufficient consumer representation on advisory boards, the power given to national advisory councils to overrule decisions of the responsible administrators, the failure to require State plans to set minimum standards of administration and services, and the specific prohibition of all Federal standards lead to the conclusion that Senate bill 545 does not sufficiently protect the public interest in the expenditure of public funds for medical care.

Senator Smith. Doctor, just in commenting on your statement on page 15, where you say you have suggested alternative programs—among others, Federal aid to medical education and research—you doubtless will be interested to know that the so-called National Science Foundation—that that bill has passed the Senate and is now being considered by the House, and I think we will make progress in legislation in that field.

And then your next point—Federal aid to provide needed hospital facilities: We aim next year to provide facilities.

I might also say that I never considered that S. 545 was intended to be an adequate answer to a complete, over-all national health program, but it opens the door to such a program by giving the State health organization the opportunity to study and by trial and error lead to the accomplishment of what we all want to see accomplished.

I appreciate very much your fine statement. Whether or not I agree, I appreciate your fine statement.

Senator Donnell, do you have any questions?

Senator DONNELL. Doctor, at the outset or near the outset of your statement you refer to the official statement of the American Public Health Association policy adopted, as you say, at the 1944 annual meeting.

Dr. ATWATER. That is right.

Senator DONNELL. And you state that you would like to comment on that bill—on S. 545—from the standpoint of that policy; is that right?

Dr. ATWATER. That is right.

Senator DONNELL. And the comments which you have made this morning, I take it, have been primarily from the standpoint of that policy statement. That is correct, is it not?

Dr. ATWATER. That is true.

Senator DONNELL. And you have deemed that statement of policy to be of such importance and as such a guiding principle that you have brought to us a printed copy of it which is appended here as an exhibit to your statement; that is correct, is it not?

Dr. ATWATER. That is right.

Senator DONNELL. Well, now, Doctor, I would like to get to that statement—something as to the theory of that statement—how it was prepared and by whom it was prepared.

In the first place, as I observe from the printed copy of the statement, or the prelude to it, as I understand it, the statement arose out of action taken at the annual meeting of a committee of the American Public Health Association, which annual meeting of that committee was held on October 9, 1943. That is correct, is it not?

Dr. ATWATER. That is correct.

Senator DONNELL. And that committee was a committee on administrative practice.

Dr. ATWATER. That is right.

Senator DONNELL. Now, that committee on administrative practice back on October 9, 1943, directed its subcommittee on medical care to draft a set of principles expressing the desirability or desirable content of a comprehensive program of medical care and methods of its administration and the part which public-health agencies should take in its operation. That is correct, is it not?

Dr. ATWATER. That is right.

Senator DONNELL. Now, Doctor, the subcommittee on medical care consists, if you know, of how many members?

Dr. ATWATER. Sixteen members, sir.

Senator DONNELL. Sixteen members?

Dr. ATWATER. Yes.

Senator DONNELL. And, back at the time at which the committee on administrative practice directed the subcommittee on medical care to draft this set of principles, was Dr. Joseph W. Mountin the chairman of that subcommittee on medical care?

Dr. ATWATER. He was.

Senator DONNELL. Now, as to the membership of that committee, I should like to ask you something about that subcommittee on medical care. In the first place, Dr. Mountin is himself connected, and was at that time, with the United States Public Health Service, was he not?

Dr. ATWATER. I believe that he was.

Senator DONNELL. What was his connection at that time, if you know?

Dr. ATWATER. I believe that he was then and still is chief of the States Relation Division.

Senator DONNELL. Of the United States Public Health Service?

Dr. ATWATER. Yes.

Senator DONNELL. And he is located here in Washington; is that correct?

Dr. ATWATER. That is right.

Senator DONNELL. Who is Dr. Earle G. Brown?

Dr. ATWATER. Dr. Earle G. Brown is commissioner of health of Nassau County, N. Y., but was not a member of that committee, sir.

Senator DONNELL. Wasn't he a member on June the 2d, 1944, at which time the report of a subcommittee of the subcommittee on medical care was presented?

Dr. ATWATER. I think he probably was at that time.

Senator DONNELL. I have before me what purports to be a photostatic copy of the minutes of the meeting held on June 1 and 2, 1944, of this subcommittee on medical care, and I notice that among those present, first is Dr. Mountin, whose connection with the United States Public Health Service you have indicated. And second was Dr. Earle G. Brown. Does that refresh your memory to the fact that he was at that time a member of the subcommittee on medical care?

Dr. ATWATER. I believe that is right.

Senator DONNELL. Now, Doctor, Dr. David D. Carr is listed next as having been at the meeting of the subcommittee on medical care on June 1 and 2, 1944. Who is Dr. Carr?

Dr. ATWATER. Dr. Carr is the health officer of Topeka and Shawnee county, Kans.

Senator DONNELL. And the next one that appears on the list is Dr. Edwin F. Daily. He is connected with the United States Children's Bureau, is he not?

Dr. ATWATER. Yes.

Senator DONNELL. Do you know in what capacity?

Dr. ATWATER. He is at the present time Director of Public Health Service.

Senator DONNELL. What connection did he have back on June 1 and 2, 1944?

Dr. ATWATER. He was part of the staff. His exact title is not known to me.

Senator DONNELL. Mr. Graham Davis; who is he?

Dr. Atwater. He is director of research for the W. K. Kellogg Foundation in Battle Creek, Mich.

Senator Donnell. I might state for the record that he is the next man who is listed as having been present.

Now, Doctor, Dr. I. S. Falk, who is connected with the Social Security Board, next appears.

Dr. Atwater. Yes.

Senator Donnell. He was there at that time, on June 1 and 2, 1944.

Dr. Atwater. Yes.

Senator Donnell. Do you know what his connection was at that time with the Social Security Board?

Dr. Atwater. I think his title was Director of the Bureau of Research, as far as I know.

Senator Donnell. Dr. J. Roy Hege is listed next as being present. Who is he?

Dr. Atwater. He was at that time the health officer of a county in North Carolina near Winston-Salem.

Senator Donnell. And Dr. Hugh R. Leavell; do you know who he was?

Dr. Atwater. He was at that time commissioner of health of Louisville, Ky. He is now professor of public health administration at Harvard.

Senator Donnell. Now, Doctor, Mr. George St. John Perrott is next shown here as having been present at the meeting of the subcommittee on medical care. He is connected with the United States Public Health Service, is he not, and was at that time?

Dr. Atwater. He is; yes, sir.

Senator Donnell. He is also a member of, and was at that time, was he not, an alternate member or substitute member of the International Labor Organization Permanent Inter-American Committee on Social Security?

Dr. Atwater. I have no knowledge.

Senator Donnell. You have no knowledge of that fact?

Dr. Atwater. No.

Senator Donnell. The next person listed as having been present at this meeting on June 1, 1944, is Miss Marion G. Randall. Do you know who she is or was?

Dr. Atwater. She is the director of the Visiting Nurse Service of New York City, formerly the Henry Street Nursing Service.

Senator Donnell. Dr. Edward S. Rogers; who is he?

Dr. Atwater. He was at that time assistant commissioner of the New York Department of Health, now dean of the University of California.

Senator Donnell. Dr. Nathan Sinai is connected with the University of Michigan, and was at that time?

Dr. Atwater. That is correct.

Senator Donnell. There was a guest present, Dr. Louis S. Reed, of the United States Public Health Service. Do you know Dr. Reed?

Dr. Atwater. Yes.

Senator Donnell. Was he present this morning?

Dr. Atwater. I saw him; that is right.

Senator Donnell. What I have read to you was, however, and is the entire list of persons mentioned as having been present at that meeting on June the 1st and 2d, 1944.

From your statement it appears that Dr. Mountin was connected with the United States Public Health Service; Dr. Daily, with the United States Children's Bureau; Dr. Falk, with the Social Security Board; Mr. Perrott, with the United States Public Health Service; and Dr. Louis S. Reed, not a member of the committee, with the United States Public Health Service. You were not present yourself at that meeting?

Dr. ATWATER. I believe I was not.

Senator DONNELL. The subcommittee on medical care was the one which had been directed to draft the set of principles, the direction having been given by the committee on administrative practice on October 9, 1943. That is correct, is it not?

Dr. ATWATER. Yes.

Senator DONNELL. Doctor, I observe in the minutes of this meeting of this subcommittee on medical care that obviously it had itself, or somebody had delegated to this body, this duty of drafting the set of principles to a smaller subcommittee of the subcommittee, and I call to your attention this paragraph in the minutes of June 1 and 2, 1944:

> The committee accordingly turned to consideration of the draft report on a national health plan which Dr. Sinai presented on behalf of the subcommittee (Daily, Falk, Reed, Rogers, and Sinai)—

Daily, he is the same Dr. Edwin F. Daily that is connected with the United States Children's Bureau; that is right, is it not?

Dr. ATWATER. That is correct.

Senator DONNELL. Falk; that is the same Dr. I. S. Falk who is connected with the Social Security Board, is he not?

Dr. ATWATER. That is right.

Senator DONNELL. This Reed, he is the same Reed who is with the United States Public Health Service, is he not?

Dr. ATWATER. I believe so.

Senator DONNELL. Rogers is the man from North Carolina?

Dr. ATWATER. He is with the New York State Department of Health.

Senator DONNELL. And Dr. Sinai. [Reading:]

> which had been given responsibility at the last meeting of the committee for drafting a program.

So this subcommittee of the subcommittee on medical care, consisting of five persons, three of whom—namely, Messrs. Daily, Falk, and Reed—were connected, respectively, with the United States Children's Bureau, Social Security Board, and the United States Public Health Service. That is correct, is it not?

Dr. ATWATER. That is correct.

Senator DONNELL. Now, this draft report now was presented, as I have indicated, to this meeting of the subcommittee on medical care June 1, 1944, having been the product of a subcommittee of a subcommittee, which subcommittee of a subcommittee contained three out of its five members who were United States Government officials in the capacities indicated.

Dr. ATWATER. Serving, however, in their individual capacities.

Senator DONNELL. Oh, yes; I understand; but they were individuals who occupied these positions with the Government to which I have referred. That is correct?

Dr. ATWATER. That is correct.

Senator DONNELL. All right. Now please consider this report, at the paragraph from the end of these minutes.

The minutes say:

> The committee spent the rest of the day in going over, sentence by sentence, the draft report. Various changes were agreed upon and with these changes the report was accepted.

Then I observe down at the bottom there is this note:

> Copy of the revised report is attached. This has been reviewed by the chairman, Dr. Sinai, Dr. Falk, Dr. Daily, and Mr. Perrott—

Now, that Mr. Perrott is on that subcommittee of the subcommittee, but he likewise is with the United States Public Health Service; that is right, isn't it?

Dr. ATWATER. That is right.

Senator DONNELL [reading]:

> and has been approved by them as correctly embodying the changes agreed upon at the meeting.

So we find then, Dr. Atwater, on June 1 and 2, 1944, this draft of principles having originated back in the meeting of October 9, 1943, having been prepared by a subcommittee of Daily, Falk, and Reed, having been reviewed by the subcommittee on medical care, which contained four members persons connected with the United States Government, this report was ultimately brought to the attention of the governing council of the American Public Health Association at the annual meeting in New York on October 4, 1944. That is correct, is it not?

Dr. ATWATER. Subsequent to a passage through the committee on administrative practice and the executive board.

Senator DONNELL. It was approved by the committee on administrative practice; is that right?

Dr. ATWATER. That is right.

Senator DONNELL. And what did you say about an executive board?

Dr. ATWATER. It was also approved by the executive board at the same time.

Senator DONNELL. Prior to presentation at the meeting in New York on October 4, 1944; is that right?

Dr. ATWATER. To the governing council.

Senator DONNELL. To the governing council?

Dr. ATWATER. Yes.

Senator DONNELL. Now, you referred in your statement here this morning—and I quote—you refer to the official statement, "Medical Care in a National Health Program," which was adopted at the 1944 annual meeting.

Now, Dr. Atwater, this 1944 meeting to which you referred, and the adoption to which you refer, was by what body?

Dr. ATWATER. The governing council of the American Public Health Association.

Senator DONNELL. The governing council of the American Public Health Association?

Dr. ATWATER. Yes.

Senator DONNELL. The American Public Health Association is quite a large organization, is it not?

Dr. ATWATER. There are at present about 11,000 members.

Senator DONNELL. Back in 1944 there were 7,493 members, were there not?

Dr. ATWATER. Approximately that number.

Senator DONNELL. Who chooses the governing council of the American Public Health Association, and who did choose it back at that time—the entire membership?

Dr. ATWATER. The fellows present and voting at the annual meeting select 30 members of the governing council. The 12 sections of the association select about 40 members of the association. The affiliated societies and branches of the association select approximately 30 more members. There are in addition certain elected officers, the president, president-elect, the treasurer, and the executive secretary.

Senator DONNELL. Was that the method in effect in October 1944 for the selection of the governing council?

Dr. ATWATER. That is correct.

Senator DONNELL. I have before me an editorial in the Journal of the American Medical Association of October 14, 1944, which I understand differs quite materially from what you have stated, and may not be quite correct. I am not doubting your statement, nor am I acceding to it, but the Journal of the American Medical Association says this with relation to the governing council:

> Now, what is the group that adopted this report? Of the 7,493 members of the American Public Health Association, 1,571 are fellows. Only fellows have a right to vote for governing councilors.

Now, that is not correct, is it, Doctor, according to your statement?

Dr. ATWATER. It is not correct, inasmuch as hundreds and thousands of members of the association vote for representatives from affiliated societies and branches.

Senator DONNELL. So this statement in the American Medical Association Journal is not correct?

Dr. ATWATER. That is not correct.

Senator DONNELL (reading):

> The vote is conducted by ballot given to each fellow when he registers at the meeting; fellows not in attendance do not have a vote. The governing council consists of approximately 100 members, of whom 30 are elected by vote of the fellows, 10 each year for 3-year terms; the rest of the members of the governing council hold membership by virtue of being section officers or representatives of affiliated (mostly State) public health associations.

Is that a correct statement?

Dr. ATWATER. That is correct.

Senator DONNELL. Doctor, do you have available and could you furnish for us for our records a copy of the constitution of the American Public Health Association, at least that portion of it which shows how the members of the governing council are selected and were selected back in 1944?

Dr. ATWATER. I shall be glad to file that for the record.

Senator DONNELL. I would appreciate it if you would, Doctor.

(Subsequently Dr. Atwater submitted the constitution referred to which was filed with the committee.)

Now, the action taken on this report of the subcommittee on medical care, a statement which it had adopted after having been prepared in the manner that I have described, the statement was adopted, as you indicated, by the governing council; that is correct, isn't it?

Dr. ATWATER. That is correct?

Senator DONNELL. And do you know how many members of the governing council were present when that statement was adopted?

Dr. ATWATER. I don't recall the number, sir.

Senator DONNELL. I have before me this editorial of the Journal of the American Medical Association, which says this, and I might just read this to you and I will ask if in any respect either presently you think it is incorrect, or upon an examination of the minutes of your organization it is incorrect, in any respect, I will ask you, if you will, to give us a statement of what transpired. This is the statement in the American Medical Association Journal:

> The motion to adopt the report—

and I interpolate; the report is the one which is referred to in the minutes, which was prepared ultimately by a subcommittee of the subcommittee and by the administrative committee and the executive board. I continue:

> The motion to adopt the report was made at the October 2 meeting of the governing council and was extensively debated at that time. Action was postponed until the October 4 meeting. At that time an amendment was offered to the motion to adopt. This amendment called for the governing council to receive this portion of the report of the committee on administrative practice and to refer it to the executive board of the American Public Health Association with instructions to confer with the board of trustees of the American Medical Association and with the American Dental Association in an attempt to arrive at a statement which these three great professional groups could support. The amendment was lost by a standing vote, approximately three to one after a voice vote had left the chair in doubt. The governing council then proceeded to vote on a motion to adopt the report; this vote was 49 aye and 14 no. The opposition to the adoption of the report was led by Drs. Walter A. Bierring, past president of the American Medical Association, Haven Emerson, and W. W. Bauer.

Is there anything in your present memory that disagrees from that statement that I read you from the Journal of the American Medical Association?

Dr. ATWATER. I believe that section of the statement is correct.

Senator DONNELL. So that according to your best recollection, subject, however, to your reexamination of your minutes, the vote on the statement of policy included that of 63 individuals in their capacity as members of the governing council, of whom 49 voted in favor of it and 14 voted against it; that is correct, is it not?

Dr. ATWATER. Am I not correct that you are quoting the vote on the amendment that was lost?

Senator DONNELL. No, sir; I am not.

> The governing council then proceeded to vote on a motion to adopt the report; this vote was 49 aye and 14 no.

Dr. ATWATER. I think that is approximately correct.

Senator DONNELL. Now, Doctor, this report which was adopted by the governing council of the American Public Health Association, as you have indicated, is the one to which you have referred as the policy statement from the standpoint of which you are this morning commenting on Senate bill 545; that is correct, is it not?

Dr. ATWATER. That is right.

Senator DONNELL. Doctor, was there considerable controversy which arose after the action taken by the governing council over the report with respect to the contents of the report and as to whether or not a proper procedure had been adopted in enabling an expression of the American Public Health Association to be made with respect thereto?

Dr. Atwater. There were those who agreed. A moderate amount of controversy arose, sir.

Senator Donnell. Yes. I want to ask you first, Who is Dr. Walter A. Bierring, this past president of the American Medical Association and one of the three gentlemen who wrote the opposition to the adoption of the report?

Dr. Atwater. He is the Commissioner of Health of the State Department of Health in Iowa.

Senator Donnell. He is a man of high standing, is he not?

Dr. Atwater. Very high.

Senator Donnell. And as indicated he was a past president of the American Medical Association.

Dr. Atwater. Yes.

Senator Donnell. That in itself indicates some idea of his standing, does it not?

Dr. Atwater. Yes.

Senator Donnell. Dr. Haven Emerson, who is he?

Dr. Atwater. He is professor emeritus of Columbia University.

Senator Donnell. A man of high standing?

Dr. Atwater. Very high.

Senator Donnell. W. W. Bauer?

Dr. Atwater. He is connected with the medical association.

Senator Donnell. And likewise a man of high standing, is he, doctor?

Dr. Atwater. Yes.

Senator Donnell. Do you know W. G. Smillie, M. D., F. A. P. H. A.?

Dr. Atwater. Very well.

Senator Donnell. He is connected with the Department of Public Health and Preventive Medicine, Cornell University Medical College, is he not?

Dr. Atwater. Yes, sir.

Senator Donnell. He is a man likewise of high standing, is he not?

Dr. Atwater. Yes.

Senator Donnell. I have before me a copy of the Journal of the American Medical Association, or, rather, a copy of the American Journal of Public Health of June 1945, which was approximately 8 months after the October meeting of the governing council, an article by him entitled "An Appraisal of a National Program for Medical Care (After Ample Opportunity to Study the Proposals)."

Dr. Atwater. I asked him to submit it for publication. I was the managing editor of the journal.

Senator Donnell. And he did submit it and it was published, was it not?

Dr. Atwater. Yes.

Senator Donnell. Before going into his article in detail I would just like to call attention to one portion of the report that was adopted by the governing council as you have indicated, and I refer to recommendation No. 2 reading as follows:

> Services should be adequately and securely financed through social insurance supplemented by general taxation, or by general taxation alone. Financing through social insurance alone would result in the exclusion of certain economic groups and might possibly exclude certain occupational segments of the population.
>
> (*b*) The services should be financed on a Nation-wide basis, in accordance with ability to pay, with Federal and State participation, and under conditions

which will permit the Federal Government to equalize the burden of cost among the States.

May I pause at that point to ask what is your interpretation of the language in connection with or in accordance with ability to pay?

Dr. ATWATER. It refers to the desirability in our opinion of having a pay-roll tax to support this kind of service which would be guaranteed in one sense, or the ability to pay. Our interpretation does not refer to procedures.

Senator DONNELL. You are talking about the financing of the system?

Dr. ATWATER. Yes, sir.

Senator DONNELL. Now, Doctor, referring again to the article by Dr. Smillie I would like to just read a small portion of it. The first part of it is preliminary and reads as follows:

> A subcommittee on medical care of the committee on administrative practice of the American Public Health Association, prepared a preliminary report on a national program for medical care which was published in the September 1944 issue of the American Journal of Public Health in order that the entire membership of the American Public Health Association might have ample opportunity to study the proposals in advance of formal action. Within a month after the report was published, it was accepted by the Committee on Administrative Practice, and adopted by the governing council of the American Public Health Association at its annual meeting on October 5, 1944.

I pause, Dr. Atwater, to inquire whether that is the meeting we have been discussing here of the governing council?

Dr. ATWATER. It is, except October 4 is the correct date.

Senator DONNELL. They have inserted October 5 instead of October 4. I continue:

> It was republished (with a few small changes) as an official statement of the American Public Health Association in the December 1944 issue of the American Journal of Public Health.

Now I would like to read the report and direct your attention to this language by Dr. Smillie. By the way, how old a man is Dr. Smillie, if you know?

Dr. ATWATER. Approximately 59.

Senator DONNELL. Has he had a wide experience?

Dr. ATWATER. Very wide.

Senator DONNELL. Do you know generally of his experience?

Dr. ATWATER. I do.

Senator DONNELL. What is it?

Dr. ATWATER. He is a graduate of Colorado College and the Harvard Medical School. He was a staff member of the Rockefeller Foundation, he served in the foreign field and in Southern States, was professor of public-health administration in Harvard before becoming professor of public health in Cornell College, of New York.

Senator DONNELL. Now, I read to you and direct your attention particularly to this article:

> This program—

and I assume he is referring to the program that you referred to this morning, and which is included as appendix A to your statement—

> This program, which has been adopted for the entire membership of the association as a body, by the governing council (without opportunity for general consideration and a full discussion), represents a revolution in Nation-wide social policy. Its implications reach deeply into the very foundations of our national

life. The program, if it is instituted as set forth in the report, will affect materially the mode of life of every living person in the Nation, and will have a still more profound effect on unborn generations. Thus, even though this hastily proposed plan has been adopted by the governing council as association policy, it would seem that further consideration of its elements, and their implications, is desirable.

You observed that portion of this article, did you, Doctor?

Dr. ATWATER. Yes; I did.

Senator DONNELL. Do you know whether or not this article was widely read throughout the United States?

Dr. ATWATER. I have no doubt it was.

Senator DONNELL. No doubt it was?

Dr. ATWATER. Yes.

Senator DONNELL. It would carry a great deal of weight, would it not, coming from a man of the standing of Dr. Smillie?

Dr. ATWATER. I am sure many people were interested in it.

Senator DONNELL. And, in your judgment, Doctor, is it not true that many persons prior to the issuance of this particular article by Dr. Smillie had expressed themselves forcefully?

Dr. ATWATER. I know of a few score who did.

Senator DONNELL. And that few score, where were they located?

Dr. ATWATER. Generally across North America.

Senator DONNELL. Generally across North America?

Dr. ATWATER. Yes.

Senator DONNELL. That is, you mean in all sections of North America; is that right?

Dr. ATWATER. That is right.

Senator DONNELL. So that this opposition of a few score, to which you refer, was not sectional or local but was widely distributed?

Dr. ATWATER. That is correct.

Senator DONNELL. Have you made any poll of any great number of persons from any certain section or did you just take the general run of expression of opinion as it came voluntarily to you?

Dr. ATWATER. We did not make a poll. We took the expression as it came in the many letters.

Senator DONNELL. By your statement "a few score" do you have any idea how many that would be?

Dr. ATWATER. I am speaking of those of whom I have personal knowledge.

Senator DONNELL. That is all I mean. Do you have any idea as to how many that you got communications from, this few score?

Dr. ATWATER. Less than 100.

Senator DONNELL. Less than 100. But you did get those expressions, though?

Dr. ATWATER. Yes.

Senator DONNELL. Were they from people of standing in their communities and in the country, according to your best judgment?

Dr. ATWATER. Here is the only measure of that, sir. Of the 7,500 members of the American Public Health Association, 2 members resigned as a result of that report.

Senator DONNELL. Who were those two members?

Dr. ATWATER. Two members resigned.

Senator DONNELL. I say who were they?

Dr. ATWATER. One was down in California, a dentist in California. The other was an elderly gentleman in New Haven, Conn.

Senator DONNELL. Do you know who the 14 members of the governing council who opposed the motion to adopt the report were?

Dr. ATWATER. I have a general recollection of who they were.

Senator DONNELL. Would you just tell us a few of them and supply the list of persons who voted for and persons who voted against it?

Dr. ATWATER. That was not made a matter of written record, sir. I would have to tell you entirely from memory. I should be disinclined to put that in the record.

Senator DONNELL. Very well.

Dr. ATWATER. They were high-grade men who opposed it and high-grade men who supported it.

Senator DONNELL. I will appreciate your desire not to put it in the record and your desire will be observed, Doctor.

Now, Doctor, I want to call attention to one or two further observations of Dr. Smillie. Referring first to this method that was adopted, this procedure that was adopted in securing the formulation of this policy, this statement on which you have placed so much importance—I am not criticizing you for doing it, but I think we have a right to go into it, to see how it was prepared and by whom it was formulated and how it was originated and the fact that three of the five persons who drafted it at the outset, Dr. Daily, Dr. Falk, and Dr. Reed, three, as I say, of the five original members of the subcommittee of the subcommittee being governmentally connected here——

I call your attention further to this language of Dr. Smillie in the article:

> The National Program for Medical Care—

That is the same document that you referred to this morning?

Dr. ATWATER. That is correct.

Senator DONNELL (reading):

> was adopted by the governing council of the association, without ample time for assimilation or analysis. It was made a general policy of the association, without an opportunity for the membership of the association to consider the matter carefully, and with all its implications.
>
> The program provides for an enormous central Federal administrative agency which imposes upon the whole American people a program of compulsory, contributory medical care which will encompass all facilities for public health, preventive medicine, epidemiology, industrial hygiene, child-health protection, together with all phases of hospital care, physician care, nursing care, convalescent-home care, rehabilitation, care of chronic illness, care of infectious diseases, care of mental illness, and a thousand other details relating to medical care and to public health and public welfare. All this is provided for, without consideration for the fundamental principles of local self-government, wherein lies the elementary strength and basic power of our American mode of life.

Doctor, this American Journal of Public Health is put out by your organization, is it?

Dr. ATWATER. That is correct.

Senator DONNELL. And it has been published for some 37 years, has it not?

Dr. ATWATER. Yes.

Senator DONNELL. And it is widely distributed all over the country and widely read and highly regarded?

Dr. ATWATER. Yes.

Senator DONNELL. And you do not publish articles in that publication unless you regard those articles as of respectability; regardless of whether you agree with them, you do not publish articles unless you think they are written by persons whose opinions are entitled to be presented to the public; that is correct, is it not?

Dr. ATWATER. And we take great pride in the freedom of speech in that journal, as shown by that article, Senator Donnell.

Senator DONNELL. Yes, sir. Now, Doctor, I call attention also to this language in Dr. Smillie's article. He says:

> A member of the governing council who has read this manuscript insists that the plan does not mean what it says, and that the real intent of this program is the establishment of a single responsible agency at each level—Federal, State, and local. Thus, Federal administrative responsibility for the plan would not be divided between the Children's Bureau of the Department of Labor, the United States Public Health Service, the Farm Security Administration, and other varied Federal agencies, but would be centered in a single national Department of Health and Welfare, with a Director who would have the status of a Cabinet member.
>
> Similarly, a single governmental agency would administer the funds at the State level, and at the local level as well. Each of these local administrative bodies would be autonomous, but their activities would be coordinated with those of the State and Federal agencies. But how much autonomy is left to the local community, if it has no responsibility for financing the program, no direct control of budgetary allotments, no voice in determination of broad general policy?

Mr. Chairman, I ask that the entire article of Dr. Smillie be incorporated as a part of the record in this proceeding.

Senator SMITH. It is so ordered.

(The article referred to follows:)

AN APPRAISAL OF A NATIONAL PROGRAM FOR MEDICAL CARE (AFTER AMPLE OPPORTUNITY TO STUDY THE PROPOSALS)

(By W. G. Smillie, M. D., F. A. P. H. A., department of public health and preventive medicine, Cornell University Medical College, New York, N. Y.)

A subcommittee on medical care of the committee on administrative practice of the American Public Health Association, prepared a preliminary Report on a National Program for Medical Care which was published in the September 1944 issue of the American Journal of Public Health, in order that the entire membership of the American Public Health Association might have ample opportunity to study the proposals in advance of formal action. Within a month after the report was published, it was accepted by the committee on administrative practice, and adopted by the governing council of the American Public Health Association at its annual meeting on October 5, 1944. It was republished (with a few small changes) as an official statement of the American Public Health Association in the December 1944 issue of the American Journal of Public Health.

This program, which has been adopted for the entire membership of the association as a body, by the governing council (without opportunity for general consideration and a full discussion), represents a revolution in Nation-wide social policy. Its implications reach deeply into the very foundations of our national life. The program, if it is instituted as set forth in the report, will affect materially the mode of life of every living person in the Nation, and will have a still more profound effect on unborn generations. Thus, even though this hastily proposed plan has been adopted by the governing council as association policy, it would seem that further consideration of its elements, and their implications, is desirable.

The report, in its final form, is divided into 3 parts—A, the needs; B, the objectives; C, recommendations.

PART A

Part A analyzes and summarizes the present situation in relation to provision for medical care in various parts of the Nation. It sets forth the existing needs for adequate medical care clearly, comprehensively, and effectively.

PART B

There can be very little disagreement with part B of the report, which relates to the objectives of a Nation-wide plan for medical care. They are stated succinctly, and with broad foresight.

PART C

Part C consists of recommendations for immediate action. The majority of the governing council voted in favor of these recommendations, and it is quite possible that "the majority of the members of the association who have expressed themselves are in favor of the plan."

If this is true, then I gravely doubt whether these members have really thought the plan through, have understood the implications of these recommendations, and have given consideration to the situation that would develop if this program were carried to completion.

The plan, in brief, is based upon the following principles:

1. "A single responsible agency is a fundamental requisite to effective administration of the plan at all levels—Federal, State, and local."
2. The services should be financed on a Nation-wide basis.
3. Adequate support for the plan will be secured "through social insurance, supplemented by general taxation; or by general taxation alone."

Thus the plan is a comprehensive, compulsory program for complete medical care in all its aspects—curative as well as preventive—for all the people of the United States. Under the plan, the provision for medical care throughout the Nation shall be organized and administered by a central agency of the Federal Government. This administrative machinery shall extend down through the social fabric, through States, to counties, to large municipalities, to towns, to villages, and out into the rural areas, throughout the whole Nation. The program will be financed by a central source of funds which will be collected by compulsory contributions, and its administration will be imposed upon all the people, quite irrespective of local community opinions or desire.

In Eurepean governments, with a strong central organization, a type of administration that extends its tentacles from the central governing body down through all the minor units of government, and into the towns and local communities, until it invades the homes of every private citizen, is called "bureaucracy." It may be argued that Denmark and Sweden are illustrations of progressive, democratic European countries that have instituted systems of national medical care, with excellent results. The comparison is not a valid one. The United States is not a single sovereign power, but 48 separate and quite different heterogeneous States with widely divergent types of population, systems of government, and modes of life.

Those who favor the plan may insist that local community rights and opinions will be given every consideration. Local autonomy is specifically excluded from any part of the original program. However, in its final form in the December issue of the Journal, a qualifying clause was inserted:

Recommendation I, part C—"Insofar as may be consistent with the requirement of a national plan, States and communities should have wide latitude in adapting their services and methods of administration to local needs and conditions."

If administration of services is the function of a single responsible agency at all levels—Federal, State, and local—as stated in recommendation III, part A, then local communities can have no autonomy, no outlet for initiative, no chance for expression of local opinion as to local needs, no opportunity to formulate local policies.

It is an axiom that the principle of local self-government is the very core of our national strength. This principle is so fundamental to individual and family life that we can conceive of no other type of existence. We are so accustomed to it that we forget its essential components, and we are quite vulnerable to encroachment, because we take these things so for granted.

Our governmental concept is, basically, local self government, simple and representative. There is a larger unit, the State, which is the sovereign power, and which does the will of the people. The Federal Government has limited powers only, that are granted by the States. These Federal powers relate to these matters that are of interstate import. As the Nation has grown, and particularly during periods of great emergency and stress, such as world wars and world-wide depression, the Federal Government has been granted emergency powers of wide scope. This is an unfortunate concomitant of great emergencies. But these facts do not modify the principle that local self-government is the keystone of our democracy.

Why is it necessary to restate here these elementary principles of civics that we learned in childhood? What have they to do with a national program for medical care?

Let us examine the program closely. Does it build local autonomy and local community participation into the structure of the plan as a keystone?

Throughout the recommendations the plan insists upon a single, enormous, central administrative body. Local health agencies are mentioned only twice—in each instance to point out that they shall be submerged and eliminated as independent bodies. Local health services are specifically mentioned in the following clauses of the report:

Recommendation III, part A—"A single responsible agency is requisite to effective administration at all levels—Federal, State, and local."

Recommendation V, part A—"The activities of the multiple national, State, and local health agencies should be coordinated with the services provided for by a national program. There is no * * * administrative justification for dividing human beings * * * into many categories to be dealt with by numerous independent administrations."

Those members of the subcommittee who aided in drafting the plan, and who discuss its administration in the December issue of the Journal, are at variance in their interpretation of its meaning.

Dr. Mountin first points out that the "intemperate support of limited remedial measures by partisan groups" has required that some responsible agency shall step in and give technical direction to the public movement for better medical care.

A captious critic might suggest that we, as public health administrators, may be accused of self interest, bias, and partisanship, since it is claimed throughout the report that we are obviously the only suitable persons to be chosen to organize and administer this program for national medical care.

Dr. Mountin, in one sentence, recognizes "the desirability of decentralized operations, with participation by State and local authorities." But in the next sentence he states that "an unrelated series of State and local plans cannot assume a suitable service [which is] national in scope. Only the Federal Government through its broad powers of taxation can compensate for those differences in income which exist among individuals and lesser units of government."

Later Dr. Mountin states that the subcommittee believes that local health agencies should take a prominent part in the administration of health care. Existing local political boundaries will be dissolved. A new local jurisdiction will be formed which will be constituted of "natural lines of trade area." These may not be confined to a given State, but may extend to extra-State zones. Each State will be divided into suitable administrative jurisdictions, and the whole financed through a system of Federal taxation and social-security contributions. This plan may provide for decentralized administration, but it does not provide for local autonomy. Rather, it incorporates local self-government under Federal jurisdiction.

Dr. Sinai passes by the whole administrative problem lightly. He states that much time will doubtless be spent in debate upon relationships between the Federal and State Governments in a scheme of national health. This matter, he says, is a subject which should not preoccupy us. Broad policy making, according to Dr. Sinai, must be the responsibility of the Federal or the State Government: "Detailed administration must be centered where the people live, and must be related to local conditions and needs." He believes that "local administration of finances is not a necessary accompaniment of local administration of services." The implications of this type of organization are perfectly clear to an experienced administrator. It is the very antithesis of our conception of local self-government.

Dr. Hege, who is an experienced local health officer, has an entirely different conception of a national program for medical care from the others participating in the discussion. He assumes that the primary administrative responsibility for operation of the health-care program will lie within the State. He insists that "there must be decentralized control of health services, that the people of each area must have a good deal of choice as to what their health service shall be and how it shall be administered."

He also points out that the program should develop slowly, over a long period of time. Different types of administration should be set up in different communities to meet local needs—"for we shall learn by doing." "The final answers to administrative problems throughout the Nation will not be uniform."

If Dr. Hege's interpretation of the national program for medical care is a correct one, then one can have little fault to find with it. But it is not the program as it is presented to the readers of the journal. Perhaps, after all, the program doesn't mean what the words say.

A member of the governing council who has read this manuscript insists that the plan does not mean what it says, and that the real intent of this program is the establishment of a single responsible agency at each level—Federal, State, and local. Thus, Federal administrative responsibility for the plan would not be divided between the Children's Bureau of the Department of Labor, the United States Public Health Service, the Farm Security Administration, and other varied Federal agencies, but would be centered in a single national Department of Health and Welfare, with a director who would have the status of a Cabinet member.

Similarly, a single governmental agency would administer the funds at the State level, and at the local level as well. Each of these local administrative bodies woud be autonomous but their activities would be coordinated with those of the State and the Federal agencies. But how much autonomy is left to the local community if it has no responsibility for financing the program, no direct control of budgetary allotments, no voice in determination of broad general policy?

The program as actually presented in the report is as follows:

The Federal Government, with some State participation, collects and distributes the funds for the medical services for the Nation as a whole. This is accomplished by a tremendous bureaucratic machine which coordinates all medical services of whatever nature, in every community in the land, down to the last physician, nurse, local hospital, and local health center. All public-health activities, as well as all medical and hospital services, will be under the direct administration of "a single responsible agency."

Under a plan of this type, local agencies for provision of medical care, and local health departments also, will not be autonomous, independent, participating, representative governmental units, but will be subservient to the Federal over-all plan; dependent upon it for local policies, for selection of personnel, for formulation of programs, and completely dependent upon it for funds. This is not a stimulation of local self-government, but engulfment. It is not independence, but elimination of local community initiative and local responsibility.

The State health departments, as well as other State agencies that are now empowered to furnish medical and public-health care, fare no better under the plan than do the health services and medical-care facilities of local communities. They become, in fact, branches or subdivisions of a central agency—distributors of the funds of the Federal collecting and distributing body.

The respective States are asked to make a study of their local needs, and to promulgate a State-wide master medical-care program, which, on a long-term basis, will eventually meet the local community needs insofar as they may be foreseen. It is also suggested that States may be permitted to participate in the financing of the plan.

But the collection and distribution of the mammoth medical-care fund is in the hands of the national body, "a single responsible agency," which obviously holds veto power over all State, as well as local community, personnel, plans, or new proposals.

SUMMARY

The national program for medical care was adopted by the governing council of the association, without ample time for assimilation or analysis. It was made a general policy of the association, without an opportunity for the membership of the association to consider the matter carefully, and with all its implications.

The program provides for an enormous central Federal administrative agency which imposes upon the whole American people a program of compulsory, contributory medical care which will encompass all facilities for public health, preventive medicine, epidemiology, industrial hygiene, child-health protection, together with all phases of hospital care, physician care, nursing care, convalescent-home care, rehabilitation, care of chronic illness, care of infectious diseases, care of mental illness, and a thousand other details relating to medical care and to public health and public welfare. All this is provided for, without consideration for the fundamental principles of local self-government, wherein lies the elementary strength and basic power of our American mode of life.

It would seem to be more appropriate, in planning for the development of a Nation-wide program for medical care, to utilize the genius of the American people for local self-government, to employ the enormous latent forces of voluntary cooperative enterprise, to develop a medical-care program slowly and progressively on a local community basis, building on the sound foundation of local community autonomy, with State guidance, and with State assistance when necessary; and with Federal encouragement by subsidy to those communities in greatest need.

It is quite possible that I have not interpreted the basic purposes and intent of this report correctly, and that local autonomy will become the cornerstone upon which a national program for medical care will be built. Perhaps some may feel that local autonomy is not an essential part of a Nation-wide medical-care program. In any case, further discussion in the American Journal of Public Health of the plan and of its full implications seems most desirable.

Senator DONNELL. Now, Doctor, I shall push on as rapidly as I can and I assure you that I am not so far away from the conclusion of our discussion.

In the first place, you are familiar with the International Labor Organization, with which Mr. Perrott is connected as a substitute delegate in the Permanent Inter-American Committee on Social Security. You are familiar with that, are you not—with that organization?

Dr. ATWATER. I am familiar with the International Labor Organization.

Senator DONNELL. But you do not know about the connection of Mr. Perrott, however?

Dr. ATWATER. I do not.

Senator DONNELL. You are aware also that Dr. Falk is connected with the International Labor Organization?

Dr. ATWATER. I was not aware of that.

Senator DONNELL. Now, I ask that there be introduced into the record, Mr. Chairman, another excerpt from the American Medical Association Journal of September 2, 1944, entitled, "The International Labor Organization on Sickness Insurance." I ask that that be inserted in the record.

Senator SMITH. It is so ordered.

(The article referred to follows:)

[From the American Medical Association Journal, September 2, 1944]

THE INTERNATIONAL LABOR ORGANIZATION ON SICKNESS INSURANCE

Possibly the action of the International Labor Organization at its twenty-sixth conference in Philadelphia during April and May of the present year may have a greater influence on sickness insurance legislation than any of the laws proposed in Congress.[1] Delegates from 41 nations composed this conference, including nearly all Allied and neutral nations except the Soviet Union. There are four representatives from each nation. Two of these are appointed by the government, and one is chosen by employer and the other by labor organizations.

The recommendations for sickness insurance are more elaborate than those of any previous conference. They constitute a complete outline for legislation; if previous experience points to future possibilities, these recommendations are likely to be followed in legislation introduced in nearly all the countries not having sickness insurance at the present time. Some of the features in the recommended legislation especially suggested are as follows:

"The medical care service should cover all members of the community, whether or not they are gainfully occupied.

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[1] International Labor Conference, Provisional Record, 26th sess., Philadelphia No. 30. Social Security Bulletin, vol. 7, p. 11 (June), 1944; Monthly Labor Review, vol. 59, p. 1 (July), 1944.

"All care and supplies should be available at any time and without time limit, when and as long as they are needed, subject only to the doctor's judgment and to such reasonable limitations as may be imposed by the technical organization of the service.

"Complete and up-to-date technical equipment for all branches of specialist treatment, including dental care, should be available, and specialists should have at their disposal all necessary hospital and research facilities and auxiliary outpatient services such as nursing, through the agency of the general practitioner.

"To achieve these aims, care should preferably be furnished by group practice at centers of various kinds working in effective relation with hospitals.

"The working conditions of doctors and members of allied professions participating in the service should be designed to relieve the doctor or member from financial anxiety by providing adequate income during work, leave, and illness and in retirement, and pensions to his survivors, without restricting his professional discretion otherwise than by professional supervision, and should not be such as to distract his attention from the maintenance and improvement of the health of the beneficiaries.

"The professional supervision of the members of the medical and allied professions working for the service should be entrusted to bodies predominantly composed of representatives of the professions participating with adequate provision for disciplinary measures.

"The central government agency should consult the representatives of the medical and allied professions, preferably through advisory committees, on all questions relating to the working conditions of the members of the professions participating, and on all other matters primarily of a professional nature, more particularly on the preparation of laws and regulations concerning the nature, extent, and provision of the care furnished under the service."

Group medical service is recommended, and governments are urged to provide equipment for medical centers. The use of salaried physicians is recommended under certain circumstances.

The health sections were adopted by a vote of 76 to 6, with 23 extensions. The attitude of one of the employers' representatives, Henry I. Harriman of the United States, who voted against the health section, was expressed as follows:[2]

"The employers' group was frankly surprised at the universality of the demand for all-inclusive social-security legislation. It was their feeling, as it is mine, that such laws must come as a matter of evolution and I personally voted against the final resolution, feeling that it went too far and too fast.

"Now that I am back from Philadelphia and have had an opportunity to view the conference with better perspective, I feel that the employers of the United States must face the demand for enlarged social security and that if they are wise they will not try to stop the enactment of such laws but will guide them into sound and reasonable form."

Senator DONNELL. And also that there be inserted from the same publication of the September 1944 issue another article entitled, "Another Compulsory Sickness Insurance Plan," a very small portion of which I desire to read for identification purposes at this point:

The subcommittee on medical care of the committee on administrative practice of the American Public Health Association has submitted a "preliminary report" on the national program for medical care. This report appears in the September 1944 issue of the American Journal of Public Health (p. 984). The program suggested follows closely the recommendations of the International Labor Organization on sickness insurance already described in the journal.

The similarity is shown in the following selection from the preliminary report of the subcommittee on medical care.

Following which are certain remarks and then this observation:

There is more of a similarity to the Wagner-Murray-Dingell bill than is found in the original recommendations of the International Labor Office in that the Public Health Department is proposed as the administrative agency and that the role of the medical profession is reduced to representation in an advisory commission.

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[2] Best's Insurance News, vol. 45, p. 27 (August), 1944.

I call attention also to the fact that the membership of the subcommittee is set forth in this article, headed by Dr. Mountin as chairman, Brown, Carr, Falk, and others who have been mentioned here this morning.

Senator SMITH. The entire article will be incorporated in the record.

(The article referred to follows:)

MEDICAL ECONOMIC ABSTRACTS

ANOTHER COMPULSORY SICKNESS INSURANCE PLAN

The subcommittee on medical care of the committee on administrative practice of the American Public Health Association has submitted a preliminary report on the national program for medical care. This report appears in the September 1944 issue of the American Journal of Public Health (p. 984). The program suggested follows closely the recommendations of the International Labor Organization on sickness insurance already described in the journal.[1]

The similarity is shown in the following selection from the preliminary report of the subcommittee on medical care:

"A national program for medical care should make available to the entire population, regardless of the financial means of the individual, curative services.

"Services should be adequately and securely financed through social insurance supplemented by general taxation, or by general taxation alone.

"The public health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future.

"The agency authorized to administer such a program should have the advice and counsel of a body representing the professions, other sources of service and the recipients of services."

There is more of a similarity to the Wagner-Murray-Dingell bill than is found in the original recommendations of the International Labor Office in that the Public Health Department is proposed as the administrative agency and that the role of the medical profession is reduced to representation in an advisory commission.

The members of the subcommittee submitting the report are Joseph W. Mountin, M. D., chairman; Earle G. Brown, M. D.; David D. Carr, M. D.; Edwin F. Daily, M. D.; Graham Davis; I. S. Falk, Ph. D.; J. Roy Hege, M. D.; Hugh R. Leavell, M. D.; Emory Morris, D. D. S.; George St. J. Perrott; Marion G. Randall, R. N.; Edward S. Rogers, M. D., and Nathan Sinai, D. P. H.

PROGRESS OF MEDICAL SERVICE PLANS

Medical-Surgical Plan of New Jersey.—The first contracts were issued in July 1942. It serves the State of New Jersey and offers both medical and surgical contracts. On December 31, 1943, it had a total membership of 7,334 males and 8,681 females, including both subscribers and dependents. During 1943 it had an income from subscribers of $74,498.47, expended $67,348.46 and accumulated a surplus of $12,201.35.

California Physicians' Service.—This was organized in 1939 and serves the State of California. On March 31, 1944, it had contracts covering 38,990 males and 53,010 females, making a total of 92,000. Its income to the date mentioned was $1,280,054.03; disbursements amounted to $1,206,401.39, leaving a net gain of $73,652.64. It now has a stabilization fund of $90,165.

Senator DONNELL. Now, Doctor, I want to ask you just one or two very short questions in regard to the importance of this statement on which you have relied this morning. It has been relied upon very extensively by Senator Wagner in connection with his program or presentation of the Wagner-Murray-Dingell bill. You are familiar with that fact?

Dr. ATWATER. I was not aware that he had depended on it.

Senator DONNELL. You are not aware of that?

Dr. ATWATER. No.

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[1] Journal of American Medical Association, vol. 12, pp. 32–33 (September 2), 1944.

Senator DONNELL. Well, I might then state to you, Doctor, that as I understand it when he introduced the national health bill of 1945 he referred to two documents. One, the principles of a Nationwide health program, which has hitherto been identified in these hearings, the same having been issued by the Committee on Research on Medical Economics, which was described by Dr. Boas as a committee that consisted of approximately 10 persons, of which committee Mr. Michael M. Davis is chairman. And, by the way, who is Michael M. Davis?

Dr. ATWATER. Michael Davis, Ph. D., is a student of medical care and hospital service in New York, with offices at 1790 Broadway.

Senator DONNELL. That is the same Michael M. Davis who appears in the minutes of the medical health program?

Dr. ATWATER. Yes.

Senator DONNELL. I wish to call attention to the fact that in this program of the medical health program there appears the name of Dr. I. S. Falk, Mr. George St. John Perrott of Washington, along with Dr. John P. Peters and various other persons who have been mentioned from time to time.

Senator Wagner, as I say, referred extensively to this document entitled, "Principles of a Nation-Wide Health Program" when he introduced the national health bill in 1945.

A second supporting document which was referred to by Senator Wagner was this policy statement adopted by the 1944 meeting of the American Public Health Association governing council to which you refer.

Doctor, you have made various observations with regard to the bill. I presume Senator Smith may want to ask you some few questions on that.

Senator SMITH. I have none.

Senator DONNELL. I think that is all, Doctor.

Senator SMITH. That is all, Doctor. Thank you very much for your testimony.

Before calling the next witness, at the request of Senator Pepper, I want to introduce into the record at this time a letter from Senator Pepper dated May 26, 1947, addressed to Dr. George Baehr, president of the New York Academy of Medicine, who testified at one of the early hearings of this committee, and the reply of Dr. Baehr to Senator Pepper, dated June 3, 1947, written from the New York Academy of Medicine in New York; and also an editorial from the Christian Science Monitor of May 29, 1947, entitled, "Questionable Tactics."

(The letters and editorial referred to follow:)

MAY 26, 1947.

DR. GEORGE BAEHR,
President, New York Academy of Medicine,
New York, N. Y.

DEAR DOCTOR BAEHR: I just wanted to write and tell you how much I enjoyed meeting you and listening to your testimony on the Taft health bill. I am sure that you will excuse me for what seemed to be my brusqueness and anxiety in my questioning at the hearing. It results from my deep feeling about the great need for medical care for all of our people, which I am sure you share with me.

I just wanted to take this opportunity to call to your attention some facts concerning your testimony and discussion with Senator Donnell at the hearing concerning the cost of a national health insurance program. In the course of your testimony reference was made to pages 215 and 216 of the report of the New York Academy of Medicine, entitled "Medicine in the Changing Order." As you probably realize these costs include the estimated expenditures for all forms of social insurance, including all forms of medical benefits. It was not made clear at the hearing that the costs of medical benefits under the earlier Wagner-Murray-Dingell bill would be substantially less than the amounts shown on pages 215 and 216 of the report. In fact, the estimated cost would not be over 3½ to 4 billion dollars annually.

I hope you will take the opportunity to correct the record to make clear the true cost of a national health insurance program.

I hope I will have the pleasure of meeting with you again.

Always sincerely,

CLAUDE PEPPER.

THE NEW YORK ACADEMY OF MEDICINE,
New York 29, N. Y., June 3, 1947.

The Honorable CLAUDE PEPPER,
United States Senate, Washington, D. C.

DEAR SENATOR: I have reread pages 215 and 216 of the report of the New York Academy of Medicine entitled "Medicine in the Changing Order." On page 215, preceding the tabulation of the figures which were quoted by Senator Donnell, it is specifically stated that the estimates are "of the over-all costs of all the benefits and services, including all forms of medical benefits afforded by the Wagner-Murray-Dingell bill." I do not believe that this statement could be interpreted to mean that the figures given were only for "medical costs." The Wagner-Murray-Dingell bill as formulated specifically provided for a block of social insurance benefits to be financed through a single wage-tax deduction.

According to bill S. 1050, the total tax financing represents 8 percent of the wage bill up to $3,600 (4 percent from the employer and 4 percent from the employee). Of this collection, 3 percent was allocated to medical care and hospitalization insurance. Senator Wagner's estimate was close to 12 billion, and three-eighths of that would be approximately 4½ billion.

In view of the fact that you feel that my answers to Senator Donnell's questions might be subject to misinterpretation, I shall ask that a footnote be appended which will quote the last paragraph on page 215 of the volume on "Medicine in the Changing Order." This should leave no doubt as to the significance of the figures which were quoted at the hearing.

I greatly enjoyed my experience in Washington at the hearings and hope that my replies to your questions were sufficiently responsive. I have no doubt that we have the same objective, although we approach it in a totally different manner because of what seems to us to be good and sufficient reasons.

Sincerely yours,

GEORGE BAEHR, M. D., *President.*

[From the Christian Science Monitor, Boston Mass., May 29, 1947]

QUESTIONABLE TACTICS

It is curious that President Truman at this late date in the session should ask Congress to set up a national system of medical care and disability insurance. Congress has come so near its close that Senator Taft says his own medical measure does not seem likely of passage.

Beyond that the cost of the compulsory insurance proposed is estimated by authorities as $11,000,000,000 a year or more. The expense would be so great that sponsors of the legislation grant that pay-roll taxes on employers and employees would not suffice, and the Government would have to help out with a subsidy. But the trend in Congress is for trimming expenditures rather than boosting them. Also the Republican majority is against compulsory sickness insurance.

Knowing these obvious facts, the President sent his message to time with introduction of the new Wagner-Murray-Dingell bill on the following day. For some years this has been the outstanding vehicle of socialized medicine. These moves indicate that President Truman, with an eye to labor support, will urge Government sickness insurance as a plank in next year's national Democratic platform.

Not all labor leaders, however, favor it. Many who have had experience with sickness insurance in their own unions do not. The southern Democrats will be hostile. This may not be good politics, even in the President's own party.

As for the general public, though a few Washington officeholders have promoted much propaganda under Government auspices, the project has never developed a wave of popular sentiment.

President Truman accepted some very poor counsel from his labor advisers last year and appears to be getting little better today on socialized medicine.

(Subsequently Senator Smith addressed the clerk as follows:)

UNITED STATES SENATE,
July 17, 1947.

PHILIP R. RODGERS, Esq.,
Committee on Labor and Public Welfare, United States Senate,
Washington, D. C.

MY DEAR MR. RODGERS: At Senator Smith's request I am enclosing correspondence and other material from Dr. Reginald M. Atwater, executive secretary of the American Public Health Association. I am also enclosing correspondence with Senator McGrath together with some newspaper clippings he sent to the Senator.

Upon receipt of this material, will you please speak to Senator Smith about it as he would like to talk over with you the proper places to insert this material in the record of the health hearings.

Enclosed also is the original letter from Dr. George F. Lull, secretary of the American Medical Association, dated July 9, 1947. You have a copy of this letter in your files and Senator Smith suggests you keep the enclosed original and send the copy to us for our files.

Very truly yours,

ELIZABETH WHERRY.

THE AMERICAN PUBLIC HEALTH ASSOCIATION,
New York 19, N. Y., July 3, 1947.

Hon. H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: At the hearing of the Subcommittee on Health over which you presided on June 27, Senator Donnell, you will recall, inserted in the record considerable material from the Journal of the American Medical Association and the American Journal of Public Health on which he requested me to send him comments pointing out any errors of fact.

I have sent Senator Donnell the attached letter with the information which he has requested and would respectfully ask that, in view of the fact that I was not prepared at the time to comment in detail on this material dating back some 3 years, it would be appropriate for it to be inserted in the record in order that the full story may be available to you and the other members of the committee in your consideration of Senate bill S. 545.

Faithfully yours,

REGINALD M. ATWATER, M. D.,
Executive Secretary.

JULY 14, 1947.

Dr. REGINALD M. ATWATER,
Executive Secretary, the American Public Health Association,
New York 19, N. Y.

MY DEAR MR. ATWATER: Yours of July 3 is received enclosing copy of your letter of the same date to Senator Donnell and also certain other enclosures which you request be inserted in the record of our health hearings in our consideration of Senate bill S. 545.

I am inserting all these enclosures except the constitution and bylaws of the American Public Health Association which I am filing with the committee records for reference by the committee when we study the record in connection with the preparation of our report in the next session of Congress.

Always cordially yours,

H. ALEXANDER SMITH.

THE AMERICAN PUBLIC HEALTH ASSOCIATION,
New York 19, N. Y., July 3, 1947.

HON. FORREST C. DONNELL,
Senate Office Building, Washington, D. C.

DEAR SENATOR DONNELL: In accordance with your request of June 27 at the hearing of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, I give you the following supplemental information.

You will recall that you read into the record of the hearing an editorial beginning on page 434 of the Journal of the American Medical Association, October 14, 1944, relating to the declaration on Medical Care in a National Health Program which had recently been adopted by the American Public Health Association. You asked me to advise you of any errors of fact contained in this editorial.

In answer to your question, I enclose a copy of a letter to the editor of the Journal of the American Medical Association published in the November 18, 1944 issue commenting on this editorial from Edward S. Godfrey, Jr., M. D., then commissioner of health in the State of New York, who is chairman of the Committee on Constitution and Bylaws of the American Public Health Association. It will be noted that Dr. Godfrey was in the minority group on the governing council who, in the opinion of the editor of the Journal of the American Medical Association, were unfairly treated. Dr. Godfrey speaks with first hand knowledge of the facts.

It is respectfully suggested that this letter of Dr. Godfrey's in answer to the editorial in question be included in the record because it points out the fallacy of the editor's claim that the action was not of a democratic sort or truly representing the sentiment of the Association.

There is an error in fact in the editorial in question in that the total membership of the American Public Health Association is given as 7,493, whereas the correct figure at that date was 9,064, which figure is a total of the two figures given in the editorial for members and Fellows.

As pointed out by Dr. Godfrey's letter, it is not true that only fellows had a right to vote for governing councilors as stated in the editorial. The fact is that only fellows present at the annual meeting had a right to vote for the elective councilors, 10 of whom are elected each year for 3-year terms. Other members of the association present at the annual meeting, or present at the meetings of affiliated societies or branches, had the right to vote for the other members of the governing council, numbering approximately 70. The council therefore directly represents the membership of the association.

The American Public Health Association has pride in the record of its democratic procedure and, as secretary of the governing council at the 1944 annual meeting, I can testify that the vote of the governing council members of 49 to 14, favoring adoption of out statement, was as truly a democratic expression of a majority opinion as a similar vote of the United States Senate might be. The fact that subsequently there has appeared no move to reverse the action speaks for itself.

In accordance with your request, I submit a copy of the constitution and bylaws of the American Public Health Association in effect in 1944 with the paragraphs related to the election of governing councilors marked.

Since you are interested in the make-up of the subcommittee on medical care, I take the liberty of enclosing a list of the members of that subcommittee, together with a list of the members of the committee on administrative practice to which it is subordinate as of that date, and a list of the members of the governing council. It will be understood that these persons serve in their private capacity but their public position will be recognized as of the very highest.

You will recall that you inserted in the record the paper by Dr. W. G. Smillie entitled "An Appraisal of a National Health Program for Medical Care," published in the June 1945 issue of the American Journal of Public Health, calling attention to the fact that such a critical point of view appeared in the official publication of the American Public Health Association.

As chairman of the editorial board and managing editor of the American Journal of Public Health, let me say that the board encouraged the publication of this minority point of view. The association as a matter of principle welcomes such independent thought and takes real pride in this tradition of free speech. We wish that other professional journals had as liberal a policy in this regard.

In view of the fact that the record of the hearing of June 27 contains considerable material, included at your request, on which I was not prepared to comment in detail at the time, it is respectfully requested that this letter and such of the supporting documents as seem proper should be included in the transcript of the hearing.

Very sincerely yours,

Reginald M. Atwater, M. D.,
Executive Secretary.

The American Public Health Association

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[Copy of letter from Edward S. Godfrey, Jr., M. D., commissioner of health, Albany, N. Y., to the editor, Journal of the American Medical Association, November 18, 1944, vol. 126, No. 12, p. 789]

I have noted with regret the leading editorial in your issue of October 14 entitled "American Public Health Association Health Insurance Declaration." As one of those who voted for the proposed amendment and against the final adoption of the report, I wish to correct certain prejudicial impressions which I believe will be given to a body of your readers relative to the representative character of the governing council.

I am willing to accept the figures given in the editorial as to the number of members and fellows, respectively, in the American Public Health Association. I would call attention, however, to the fact that the only members of the governing council whose election is restricted to a vote of the fellows are the 30 out of something over 100 mentioned in your editorial. The 41 members of the council representing the sections are elected by the membership and fellowship of each section.

Likewise, representatives of the affiliated societies and branches are elected by their fellowship and membership in accordance with their respective constitutions and bylaws.

The council is, therefore, a representative body, as is the house of delegates of the American Medical Association. Membership in the council and the right to hold office in the association are restricted to fellows, as they are in the American Medical Association.

The adoption of the subcommittee's report by a large majority of the quorum present is therefore quite as proper and as much in order as any action taken by the house of delegates of the American Medical Association and, in my opinion, equally representative of the opinion of the entire membership.

I voted for the amendment proposed by Dr. Bierring because I feel that the cooperation of the medical and dental professions is essential to the successful operation of any plan designed to extend medical care and to improve its quality.

On the other hand, I think that the attitude of the American Medical Association has been such that a majority of the council felt that a conference on the subject would prove futile and would merely delay an expression of opinion from the American Public Health Association on a subject on which their minds were made up. The tone of your editorial would tend to confirm that opinion.

My vote against the resolution to adopt was based on my not having taken time, personally, to examine the report and study its content.

STATEMENT OF DR. THEODORE SANDERS, FOR THE NATIONAL FEDERATION OF SETTLEMENTS AND THE NATIONAL ASSOCIATION OF CONSUMERS

Senator SMITH. Will you state for the record, unless your statement does so, just a little biography of your experience and background and qualification to testify here?

Dr. SANDERS. Well, I am a graduate of Columbia College, Columbia Medical School.

Senator SMITH. In New York you mean?

Dr. SANDERS. Yes; New York City.

Senator SMITH. Is that the P. and S.?

Dr. SANDERS. That is the P. and S.

Senator SMITH. College of Physicians and Surgeons of Columbia University.

Dr. SANDERS. That is right, and practiced medicine for 32 years in New York City.

Senator SMITH. I know from your statement that you are appearing at the request of the National Federation of Settlements and National Association of Consumers; is that right?

Dr. SANDERS. Yes, sir.

Senator SMITH. Will you go ahead, Doctor? We will be glad to hear your testimony. Let me ask you first whether this document that I hold in my hand is the document you want entirely incorporated in the record and you are planning to read this document?

Dr. SANDERS. Yes; I would like to read it. It is only three pages, Senator.

Senator SMITH. You may go ahead.

Dr. SANDERS. I am speaking to you at the request of the National Federation of Settlements and the National Association of Consumers. Both organizations are vitally interested in the distribution of good medical care to all Americans everywhere. The settlements saw the need for better medical care in their neighborhoods as far back as 1917 and at that time passed a resolution favoring compulsory health insurance as the only self-respecting way to protect the low-income families among whom they worked. In 1933 the settlements found unemployment and sickness compounded and passed the following resolution:

> *Resolved*, That the national federation endorse the method of health insurance as necessary to secure the benefits of modern medical skill to the masses of the country.

About 1932, inspired by the report on the Cost of Medical Care during the Hoover administration, the members of the welfare committee of the City Club of New York did research and study and became engrossed in this important subpect. We did, on a more modest scale of course, just what you are doing; we interviewed all the experts we could get. Those witnesses expressed all shades of opinions, from spokesmen of organized medicine to the avowed socialists. Finally these businessmen, lawyers, ministers, and I, a lone medical doctor, wrote our report. We were driven to the conclusion that only a Government sponsored and subsidized compulsory health insurance plan would cover the needs of the Nation. I believe that you gentlemen will ultimately reach the same conclusion and that you will see that the Taft health bill does not meet this need. The bill provides many necessary services but there are grave objections to it, and it certainly does not meet the Nation's need for good prepaid medical care.

Since 1932 there have been other comprehensive studies, such as the National Health Survey and the Pepper committee report. All point to the need for a national health insurance plan.

I am glad to have been chosen by the settlements and a new national group of consumers to represent them for I have felt that the settlements in my association with them have had their feet on the ground when it comes to having intimate knowledge of what happens to low-income families when sickness strikes them.

Perhaps the most gratifying compliment I ever received was when I was trying to persuade the medical board of a New York City hospital to participate in a plan for health insurance in one of our Federal and New York City housing projects. One of the doctors pointed his finger at me and sputtered, "Why, you haven't the viewpoint of a doctor at all; you think like a social-service worker."

This particular experiment of the Corlears Hook Medical Association, which set up a voluntary health insurance plan at Vladeck Houses, was sponsored by the New York County Medical Society, Henry Street Settlement, and a municipal hospital, with the local doctors cooperating. We learned that voluntary insurance had to be sold, and after an intensive drive we were able to sign up about half the tenants. The healthy tend to drop out and the sick remain when the cost of food and shelter press too hard on the family budget.

But let me tell you my fundamental objection to the Taft bill, S. 545. It requires a means test, before you may qualify as medically indigent, to receive its benefits. I can tell you from personal experience that some sick Americans would rather forego medical aid and would rather die than suffer such spiritual humiliation.

Moreover, if you define a medically indigent person, as some medical societies have, as the head of a family of four with a total net income of $3,000, which might cover over a third of the people, then the amount of money appropriated by the bill is too meager and inadequate. For I am sure that you are conscious that under the Taft bill a disproportionate part of the appropriation will have to be spent on administration in determining whether a person is eligible. Moreover, good medical care is frequently very expensive in these days of specialization. The Taft bill provides too little money to give scientific care. There will necessarily have to be bills met for the doctors, hospitals, operations, X-ray, laboratory work, drugs, appliances, and so forth. If the objective is to give good, modern medical care—and I am sure no one would wish to give less—the money is inadequate.

The question of whether the people want some form of health insurance has been answered by national opinion polls, and in a very recent poll in our State of New York the majority signified their desire for it. Perhaps you want to start cautiously by providing care for the medically needy and expanding facilities in the poorer sections of the country. But I feel sure that eventually the voice of the majority will demand a Government-sponsored, medically comprehensive compulsory health insurance plan. So why not do it at this time.

It would be unfortunate if the American people got the impression that the Taft health bill is what its name suggests—a national health bill. It is very far from that. Despite the fact that it contains some useful provisions, we would prefer to see this bill rejected since its passage might create the false impression that something positive has been done about our whole national health problem. We need to approach this problem in a far more basic and thoroughgoing fashion than the Taft bill contemplates before we can truthfully say that anything of importance has been done to make modern medical care available to all the people of our Nation.

Senator SMITH. Senator Donnell, do you have any questions?

Senator DONNELL. Just a very few.

Doctor, you refer to the National Association of Consumers, I believe, as a new organization.

Dr. SANDERS. That is a new organization; yes, sir.

Senator DONNELL. When was the organization formed?

Dr. SANDERS. I have it right here. The beginning of this year. Would you like to file with the committee this brochure of the organization?

Senator DONNELL. Yes, sir. This will be filed.

Dr. SANDERS. I would like to give you that first issue if you would like that for the record.

Senator DONNELL. These two documents will be filed with the records of the committee. They will not be set forth in full, but we will be very glad to have them.

Dr. SANDERS. All right.

Senator DONNELL. How large organization is the National Association of Consumers at this time?

Dr. SANDERS. I don't know, Senator. I really don't know.

Senator DONNELL. Don't you have any idea at all?

Dr. SANDERS. No; I really don't know.

Senator DONNELL. Do you know whether they have a few or a hundred or five thousand?

Dr. SANDERS. I don't know.

Senator DONNELL. Do you know whether they have as many as a hundred members?

Dr. SANDER. I couldn't tell you.

Senator DONNELL. Do you know whether they have 10 members?

Dr. SANDERS. I couldn't tell you.

Senator DONNELL. Well, what do you know about this organization that you are appearing for, then?

Dr. SANDERS. Well, I know it is a consumers' group who asked me to appear for them because I am a member of the New York Consumers League, which is a very large organization and is a national organization and for that reason Josephine Roach and Helen Hall asked me to speak for them. They knew my views on the subject.

Senator DONNELL. I note that the advisory council includes as its first member Mr. Bruce Bliven, editorial director, the New Republic. Do you know Mr. Bliven?

Dr. SANDERS. I have met Mr. Bliven.

Senator DONNELL. This document, as I say, and the other document likewise have been filed.

What is the National Federation of Settlements?

Dr. SANDERS. The National Federation of Settlements are a group of settlement houses all over the United States. There are 102 at the present time.

Senator DONNELL. By the way, Doctor, you might probably like to have the names of the other members of the council incorporated in our record. I don't want to put just one in in our record, unless you prefer to have that done. Do you want that done?

Dr. SANDERS. I don't care.

Senator DONNELL. The names of the officers and directors of the advisory council of the National Consumers Association will be included in the record.

(Subsequently the following roster was furnished to the clerk:)

Chairman, Helen Hall; vice presidents, Dorothy D. Bourne, and Mrs. Chase Going Woodhouse; treasurer, Newbold Morriss; secretary, Elizabeth Rohr.

Now, this organization, the National Federation of Settlements, what is that organization?

Dr. SANDERS. Well, that is an organization of settlement houses all over the United States. The president of the organization is Helen Hall, of Henry Street Settlement. I have been a member——

Senator DONNELL. She is also the head of this National Association of Consumers, I observe.

Dr. SANDERS. Yes.

Senator DONNELL. The same lady?

Dr. SANDERS. That is right.

Senator DONNELL. Very well. Go right ahead with the National Federation of Settlements.

Dr. SANDERS. My connection with them is that I have been medical adviser to the Henry Street Settlement and that I work in the municipal hospital just three blocks away from the Henry Street Settlement.

Senator DONNELL. What is the approximate membership of the National Federation of Settlements, if you know?

Dr. SANDERS. I wouldn't know.

Senator DONNELL. Do you know whether it has a hundred members?

Dr. SANDERS. Oh, many more than a hundred. There are over a hundred settlement houses, so that there would be many more members.

Senator DONNELL. But you are unable to give us an estimate of the number of members?

Dr. SANDERS. I couldn't tell you that, Senator.

Senator DONNELL. That is all.

Senator SMITH. Doctor, just one word more. Having lived in New York and having lived near New York, of course I am familiar with the Henry Street Settlement and the wonderful work it has done, and I gather from your statement, if I understand it correctly, you were looking at this matter from the standpoint of the need of the people for health insurance and you feel that the only way that can be brought about is by a universal health-insurance program.

You have not made any study of the methods involved in the collection of funds for the operation of that, which would be similar to social security, and also after the collection of those funds, the responsibility of the Government to deliver the amount of money received and the extent to which the Government would have to oversee the practice of medicine.

Dr. SANDERS. Senator, I am familiar with the aspects of compulsory health insurance and as I told you we went into a very complete study of it back in 1932, 1933 at the City Club and since that time I have been fascinated by the study.

Senator SMITH. I can realize that. The testimony that has been brought out here is that the program in the Murray-Wagner-Dingell approach would contemplate covering about 90 percent of our big population and, of course, if all of the people were taxed in order to get an over-all health coverage it would seem to imply a large Government direction at least of the whole medical profession and I should think that is the only answer to this thing, apparently, from your testimony.

Dr. SANDERS. I do think so; yes, Senator.

Senator SMITH. Then we are facing a revolution in our whole approach to our health program insofar as it would mean organizing our doctors and putting them on either Federal or State pay rolls through this type of plan.

Dr. SANDERS. I don't think that is necessary. I think a certain percentage of them would be on the Federal pay roll in these rural districts where they could not be supported by a health insurance plan, but I think the great majority of doctors will enter the plan, the great majority of them would be on either a fee-for-service or on a per capita payment from the insurance fund itself.

Senator SMITH. Some of our witnesses have suggested that the fee-for-service program could not possibly be continued under this over-all compulsory health-insurance plan. We would have to go on a per capita basis or a straight-salary basis.

Dr. SANDERS. I will agree with that, Senator. I think it is impossible to supervise the fee-for-service basis.

Senator SMITH. Ultimately we would be looking toward the abolition of the fee for service if such a plan was adopted and the Government and the physicians cooperated in carrying it out.

Dr. SANDERS. Yes; I think the fee for service would eventually go, under the compulsory health insurance.

Senator SMITH. You probably agree it would be a complete revolution in our whole social approach to the health program.

Dr. SANDERS. That would be so. I do not like to use the word "revolution."

Senator SMITH. Well, I mean it would be a profound change.

Dr. SANDERS. Yes; it would be a profound change.

Senator SMITH. Thank you very much.

Senator DONNELL. Could I ask the doctor a few more questions?

Senator SMITH. Yes.

Senator DONNELL. Doctor, I notice in looking over these papers of the National Association of Consumers that apparently the headquarters are here in Washington, 1740 K Street NW.; is that right, do you know?

Dr. SANDERS. I think that is right.

Senator DONNELL. And I observe that this document, "Monthly Bulletin, Volume 1, No. 1, April 1947," starts out with the handling of rent control and an admonition to "Write your Congressmen and Senators today urging support of the Murray-Wagner bill" and various other articles—housing, and so forth.

Do you know whether or not the purpose of this organization of National Consumers was to use it as a legislative organization for presenting matters to Members of Congress?

Dr. SANDERS. No; I don't think that is so. I read the thing and as I spoke to Miss Hall about it, it is just a consumer group trying to keep prices down, prevent rents from being raised, get good medical care. In other words, it follows the same line, I would say, or a little broader than the Consumers League, New York Consumers League, or National Consumers.

Senator DONNELL. I was just wondering concerning this National Association of Consumers, which has its main office or apparently its only office in Washington, although its chairman, Miss Helen Hall and Mr. Leon Henderson, of New York, appears on here likewise, and this refers to these various items of legislation. The question naturally arises in my mind as to whether this was an organization which had been formed recently. You say it is a new organization?

Dr. SANDERS. It is; yes, sir.

Senator DONNELL. Located here in Washington. With respect to all these admonitions to Members of Congress, which are perfectly all right to make, isn't it a fact, Doctor, that your best judgment is that this organization is one that has been formed recently to project various ideas here among Members of Congress?

Dr. SANDERS. I don't know about that. I don't think so. I think this association for consumers here at the local level, rather than at a national level, was more to keep prices down locally in the community rather than federally, but I cannot say because I don't know too much about the organization.

Senator DONNELL. You spoke of being connected with a settlement. Are you a practicing physician, Doctor?

Dr. SANDERS. Yes, sir.

Senator DONNELL. How long have you been practicing?

Dr. SANDERS. Thirty-two years.

Senator DONNELL. General practice of medicine or surgery?

Dr. SANDERS. Internal medicine.

Senator DONNELL. I see. That is all, then.

Senator SMITH. I now call Mr. Edward J. Slater, of the Essex Trades Council, Newark, N. J. For the record, I want to welcome Mr. Slater here as a New Jersey constituent of mine. We are glad to have you with us, Mr. Slater.

STATEMENT OF EDWARD J. SLATER, ESSEX TRADES COUNCIL, NEWARK, N. J.

Senator SMITH. I gather from the opening of your statement that you are here at the request of my good friend, Louis Marciante.

Mr. SLATER. That is right; representing the Essex Trades Council.

Senator SMITH. Are you an M. D., Mr. Slater?

Mr. SLATER. I am not.

Senator SMITH. Is it Dr. Slater?

Mr. SLATER. I am what is commonly called a labor skate, a labor representative.

Senator SMITH. Will you give us just a little bit of your background, or whatever you want to say for the record, your biography so to speak; not necessarily your age.

Mr. SLATER. I have no objection to giving that, too, Senator.

Senator SMITH. I don't care about that.

Mr. SLATER. My name is Edward J. Slater. I have been a labor representative for the past 25 years.

I have been secretary of the largest central labor body in the State of New Jersey for the past 10 years, secretary of the Teamsters' Joint Council, No. 73, since it has been formed, secretary of the Trades Union Law Department, which cares for attending to the wants of workers who need legal services in connection with compensation claims.

Senator SMITH. Are you a lawyer, Mr. Slater?

Mr. SLATER. I am not, Senator.

Senator SMITH. Well, I think with that statement we can continue with your testimony.

Mr. SLATER. My name is Edward J. Slater, and I am representing the Essex Trades Council, of Newark, N. J., which represents 125 unions having a membership of 80,000 members. At the request of President Louis P. Marciante, of the New Jersey State Federation of Labor, I also am here representing that organization with which there are affiliated approximately 1,000 unions with a membership of approximately 400,000.

When I asked to testify, I did not know that representatives of the State medical society and a number of organizations which it controls would already have been heard by your committee. However, I am glad that I have the opportunity of appearing after the appearance of Dr. Alexander, whose prepared statement I have read.

Many of our members are patients of the doctors who were supposedly represented by Dr. Alexander and his associates. As a trade-unionist, I believe it is perfectly legitimate for doctors to be concerned that they receive adequate pay for the services they perform, but I say frankly that I think that these doctors are moving ouside their field when they attempt to dictate the manner in which patients shall pay their bills and the manner in which tax funds collected from all the people shall be used to meet the bills of doctors who provide care to those who can't afford it.

We do not like the present manner in which we as working people have to pay our medical bills, and we cannot see that the bill of Senator Taft, S. 545, which, unfortunately, also has attached the name of Senator Smith from my State, will do anything but make this situation worse.

What is it we don't like at the present time? Those of our members who are not covered by any voluntary insurance or medical service plan simply cannot budget for their medical needs. It may be $5 this year if Johnny has a cold or it may be $1,000 if Johnny has something really serious happen to him. And, of course, if the thousand-dollar bill is for Johnny's father, who is the breadwinner, it strikes a double blow, as the family income is cut off just when the need is greatest. We have been trying to get passed in New Jersey a cash disability benefits law but have not yet succeeded. Those of our members who are in this group would like a system where they know that they have access to medical care when they need it and where they need it by the simple insurance device of paying a little each month in proportion to income.

Then we have members who are covered by so-called voluntary insurance programs and the medical-surgical program of the State medical society. We are not enthusiastic about this type of program. While it takes care of at least part of the big doctor and hospital bills, it doesn't do what we consider to be of equal importance—it doesn't pay the costs of the doctor bills for those who are ill and do not have to be hospitalized. It doesn't pay the cost of a periodic physical check-up which doctors tell us is a good thing. It doesn't pay the costs of eye tests for those workers doing fine work. It doesn't pay the costs of diagnosis before we have to go to the hospital. It doesn't pay the costs of the visits of our children to a baby doctor that the doctors say are necessary during babyhood and early childhood.

But we do not like the charity way of providing medical care for this low-income group. The charity way is the way it is now handled in most of the counties in New Jersey. We know from bitter experience, especially during the depression, that "charity" administered by public officials can be used for political purposes. But, even more important, we know that charity, when accompanied by an investigator who asks, "What do you make?" "How much insurance do you have?" "Do you have any savings?" "Do you have anyone working in your family who might contribute?" "Do you own a car?" "Is your furniture paid for?" makes a person feel very small and resentful. The doctors have a phrase for it—it destroys a person's self-respect. We think that even the doctors will agree that self-respect is an important item in preserving health.

This aspect of the Taft bill is not only its worst feature, but it destroys the very integrity of the individual on which this country is based. We don't like charity medical care in our present system, and we don't want the present system supported by Federal funds and the prestige of a bill passed by the United States Congress.

What kind of a program do we want? We think that workers should pay for doctors' care in some proportion to their earnings; that employers who will benefit from workers having adequate medical care should pay part of the bill, and that the money that is now being spent by the States and the Federal Government on care for the low-income workers should be diverted and increased and paid into a national health insurance fund. I will leave the details to be worked out by members of Congress and their economic advisers. But the principle of establishing a health insurance fund from these three sources in relation to the earning of the individual workers is what we want wholeheartedly to support. Just as workers, regardless of income, are entitled to the protection of workmen's compensation, so we believe they should be entitled to the right of health insurance protection.

Before closing, I want to take up one item from the testimony of Dr. Alexander. I have his mimeographed statement here in which he tells you of the attempt in 1939 of the medical society to gain some idea as to the, and I quote, "lack of availability of medical services within our State." He ends his statement with the sentence that out of "122 complaints registered throughout the State," after a radio newspaper campaign, "only four appeared to be legitimate."

Dr. Alexander's statement is downright misleading. It is true that in many States there are not enough doctors and nurses and hospitals. But in Essex County and in the State of New Jersey, the main question is not so much the availability of medical services as it is the existence of economic barriers, for a worker or a farmer, that restrain him from going to a doctor. If a worker is afraid he is going to have to borrow money at 6 percent interest or in case of emergency go to a loan shark and pay up to 30 or 36 percent, as he often does, if he goes to a doctor, he is going to wait as long as possible before going. And, of course, the average worker is afraid that this will be the result, because he knows that doctors have to live and that they earn their money from the fees paid by their patients. If Dr. Alexander's figures prove anything they simply prove that we have a lot of people in New Jersey who had sufficient self-respect not to want to take charity care.

We want to see doctors adequately compensated. Just as our carpenters, bricklayers, and those in other trades do not want to have the doctors tell us our trade, we don't want to tell the doctors how to keep people well or make them well after they get sick. That is their job, their profession. However, the question of how we pay our medical bills, through a national health insurance program, or voluntary programs, or on a fee-for-service basis is our business and your business.

Because we feel it is the people's business, we urge your committee to report out the national health insurance bill, S. 1320, and because we are trade-unionists, we ask that the doctors be given every opportunity, under a national health insurance program, to secure the just compensation that should be their due for the service they now render and will render in the future.

Senator Smith. I am very much obliged for your statement, Mr. Slater. I don't think anybody would disagree with the problem as you present it. It is the thing we are trying to secure.

I was particularly interested in your reference to loan sharks. Just as a matter of history, when I graduated from law school years ago I worked for a year and then developed TB and I had to go West, and I got a job with the legal aid society, and my job was to study this thing, and that is one of the terrible things in our whole society. I want to see people under health insurance to be kept from going to these loan sharks. The only thing is how we can do it practically. I don't know whether you would under the compulsory insurance plan rather have the man paid in cash or whether you think it does involve the Federal control and direction of the whole practice of medicine.

Mr. Slater. As I stated in my statement, Senator, we are willing to allow the details to be worked out by those who eventually pass a law concerning this matter; however, it could be worked out along the lines that a lot of people could go to a doctor and be served and the doctor send his bill to whatever doctor there is, to whatever authority there is to make payments to him.

Now, getting back to this question of loan shark. You probably know that over the years, for many years we in the State federation of labor in the State of New Jersey have consistently been putting in a bill there year after year to control those loan sharks, without success.

Senator Smith. I am entirely with you on that. I think it is one of the worst things that happens in our society.

Senator Donnell, do you have any questions?

Senator DONNELL. Just a very few.

Mr. Slater, you say you represent the Essex Trades Council, which represents 125 unions having a membership of 80,000 members. Has the Essex Trades Council passed any resolution with respect to either S. 1320 or S. 545?

Mr. SLATER. Yes; in respect to S. 1320 they have.

Senator DONNELL. When did they do that?

Mr. SLATER. Well, I can't give you the date, Senator; however, I could develop that information for you and furnish it for you if you wish.

Senator DONNELL. It is favorable to the enactment of S. 1320, isn't it?

Mr. SLATER. Definitely.

Senator DONNELL. And do you know whether the New Jersey State Federation of Labor has passed any resolution?

Mr. SLATER. They have taken similar action, but again, if you are going to ask when, I cannot give you the dates, but I can also get that information.

Senator DONNELL. Would you send a copy of each of those resolutions in for our records?

Mr. SLATER. Yes; I would.

Senator SMITH. To the secretary of the committee, please.

Mr. SLATER. Yes.

Senator SMITH. Thank you very much for coming here. We appreciate your testimony, and I am glad to see a friend of mine from New Jersey present.

Mr. SLATER. We are vitally interested in this matter, Senator, in the hope that you will get around to passing a bill that will set up a health-insurance program.

Senator SMITH. If there are no further witnesses, the committee will stand adjourned until next Wednesday morning at 9:30.

(Whereupon, at 11:45 a. m., the subcommittee adjourned until 9:30 a. m., Wednesday, July 2, 1947.)

NATIONAL HEALTH PROGRAM

WEDNESDAY, JULY 2, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator Forrest C. Donnell, presiding.

Present: Senators Donnell (presiding), Murray, and Pepper.

Senator Donnell. The committee will be in session.

Let the record show that Senator Smith, the chairman of this subcommittee, expresses his regrets at his inability to be present at this hearing. He is the chairman of a subcommittee of the Senate Committee on Foreign Relations, and in that capacity will be this morning engaged in conducting a hearing on the Mundt bill, H. R. 3342.

He has asked me to preside in his place in the course of this hearing. We will call the roll of the list of witnesses that I have here.

Mr. Russell Smith, is he here?

(No response.)

Doctor Peters, is he here?

(No response.)

Mr. McMichael, is he here?

(No response.)

Mr. Anderson and Mr. Paterson?

(No response.)

Very well, Mr. Biemiller, you may proceed.

Mr. Biemiller. Mr. Henderson is going to open.

Senator Donnell. Mr. Henderson, for what interests do you appear?

Mr. Leon Henderson. I am appearing before this committee on behalf of the Americans for Democratic Action.

Senator Donnell. Is Mr. Biemiller also to testify?

Mr. Leon Henderson. Yes.

Senator Donnell. We did not have on this list the fact there will be two witnesses on behalf of the same organization. We have a list of witnesses and we do not have it scheduled that you will both testify from the same organization.

Mr. Leon Henderson. My testimony will be very brief and our presentation will be limited to Mr. Biemiller who is technically competent to discuss the bill.

Senator Donnell. Mr. Henderson, what is the Americans for Democratic Action for which you appear?

Mr. HENDERSON. The Americans for Democratic Action is an organization—I might read you this statement—

> We, liberals and progressives dedicated to democratic principles and the rights of the individual under law, establish and adopt this Constitution for Americans for Democratic Action. We pledge ourselves to political action in accordance with constitutional democratic principles, on local, State, and national levels, and to the support of the progressive objectives of labor unions, of cooperatives, and farm organizations, and of other social and economic organizations of the people. We are neither a third-party movement nor a part of any political party. Our aim is to provide a medium and a program to unite the liberal and progressive forces of America to promote action for the general welfare locally and nationally.

Senator DONNELL. How large an organization is the Americans for Democratic Action?

Mr. HENDERSON. The organization at the present time has 40 chapters in 20 States, and has 70 student chapters. More local chapters are being organized all the time. The organization was consummated March 29 and 30 of this year here in the city of Washington.

Senator DONNELL. How many members do you have?

Mr. HENDERSON. I don't know how many members, since the membership is on a local basis, but there are some very substantial chapters. The 40 chapters in 20 States include the far Western States. We have chapters all the way from Tacoma to Santa Barbara. As a matter of fact, I helped to organize some of them myself on two trips to the west coast.

Senator DONNELL. Are you able to tell us whether you have as many as 5,000 members?

Mr. HENDERSON. I am quite sure we have that. There are 2,000 in the New York City organization alone. Membership recruiting has only been under way since about April 1. It is done on a local basis. There is no tallying up here in Washington at the present time of the number of members.

Senator DONNELL. Do you have any literature with you that I might have a copy of?

Mr. HENDERSON. Yes. I also have here for the record a statement of the nature of the organization and a list of its officers. I am chairman of the executive committee. Wilson W. Wyatt, of Kentucky, is the national chairman. There is also indicated the board members at large who I think you will see consist of quite a representative group.

Senator DONNELL. They are also listed here in the bulletin?

Mr. HENDERSON. This is a more complete picture.

Senator DONNELL. Do you mind filing this typewritten statement for inclusion in the record.

Mr. HENDERSON. Thank you very much. I would appreciate that.

(The statement is as follows:)

Americans for Democratic Action was established at a national conference in Washington March 29–30, 1947, when a constitution and a statement of policies were adopted and officers were elected. The national officers and the national board are as follows:

National chairman: Wilson W. Wyatt, Kentucky.
Chairman, executive committee: Leon Henderson, New Jersey.
Vice chairman: Hubert H. Humphrey, Minnesota; Franklin D. Roosevelt, Jr., New York.
Treasurer: Louis H. Harris, New York.
Secretary of board: Joseph L. Rauh, Jr., Washington, D. C.
Executive secretary: James Loeb, Jr., Washington, D. C.

BOARD MEMBERS-AT-LARGE

Harvey Brown, Washington, D. C.
Melvyn Douglas, California.
David Dubinsky, New York.
George Edwards, Michigan.
Ethel S. Epstein, New York.
William Evjue, Wisconsin.
David Ginsburg, Washington, D. C.
Lester Granger, New York.
Sal B. Hoffman, Pennsylvania.
James Killen, Washington, D. C.
Frank W. McCulloch, Illinois.
B. F. McLaurin, New York.
Othmer J. Mischo, Michigan.
Reinhold Neibuhr, New York.
Mrs. Gifford Pinchot, Pennsylvania.
Edward F. Prichard, Jr., Kentucky.
Bishop William Scarlett, Missouri.
Arthur M. Schlesinger, Massachusetts.
Paul A. Porter, Washington, D. C.
Arthur M. Schlesinger, Jr., Massachusetts.
Monroe Sweetland, Oregon.
H. L. Mitchell, Tennessee.
Mrs. M. E. Tilly, Georgia.

CHAPTER BOARD MEMBERS

Mrs. Jim Akin, Illinois.
William Batt, Jr., Pennsylvania.
Leigh Danenberg, Connecticut.
Melvyn Douglas, California.
Mortimer Hayes, Connecticut.
Louis J. Baxter, Texas.
Edward Hollander, Washington, D. C.
Eduard Lindeman, New York.
Don S. Willner, Massachusetts.

The constitution of Americans for Democratic Action provides as follows concerning the aims and objectives of the organization:

"We, liberals and progressives dedicated to democratic principles and the rights of the individual under law, establish and adopt this constitution for Americans for Democratic Action. We pledge ourselves to political action in accordance with constitutional democratic principles, on local, State, and National levels, and to the support of the progressive objectives of labor unions, of cooperatives and farm organizations, and of other social and economic organizations of the people. We are neither a third party movement nor a part of any political party. Our aim is to provide a medium and a program to unite the liberal and progressive forces of America to promote action for the general welfare locally and nationally."

At present Americans for Democratic Action has approximately 40 chapters in 20 States and is in the process of organizing local chapters elsewhere throughout the country. Membership in ADA is on a local chapter basis—that is, local chapters pass on the qualifications for membership, and issue membership cards. Members in ADA upon joining must subscribe to the following declaration of principles:

"Americans for Democratic Action is an organization of progressives, dedicated to the achievement of freedom and economic security for all people everywhere, through education and democratic political action.

"We believe that rising living standards and lasting peace can be attained by democratic planning, enlargement of fundamental liberties, and international cooperation.

"We believe that all forms of totalitarianism, including communism, are incompatible with these objectives. In our crusade for an expanding democracy and against fascism and reaction we welcome as members of ADA (or SDA) only those whose devotion to the principles of political freedom is unqualified.

"I subscribe without reservation to the principles stated above."

Senator DONNELL. Now, may I ask you whether this organization for which you have appeared considered in its conventions or meetings of its members the contents of S. 545 and S. 1320?

Mr. HENDERSON. We have not considered them as specific bills in the national convention, but I would like to read to you the statement of principles with reference to health legislation which was adopted at our March 29 convention.

This is a quotation——

Senator DONNELL. Does this appear in the Bulletin?

Mr. HENDERSON. Yes, on page 8.

We aso urge a Federal system of health insurance, Federal aid for expansion of health centers, and other medical facilities, with the widest possible use of wartime medical discoveries and Government support of medical research in special fields.

Senator Donnell. This was at the organization conference of the Americans for Democratic Action which expressed that plank to which you just referred?

Mr. Henderson. That is correct. I might tell you, Senator, that I don't know of any set of planks that were ever more democratically discussed. There was an interim committee preparing proposals which were circulated to the people who were to attend the convention—over 250 in number who came from upward of 40 States. Then they had this oportunity of making suggestions, and on one evening we had commissions which heard anybody as long as he wanted to be heard on every plank that was in that platform. After that the drafting committee of the commission retired and presented to the entire group at the next day's conference everything that had been proposed or was debated on the floor and this that you have there—the statement of principles—it was adopted practically unanimously.

Senator Donnell. Very well, Mr. Henderson, you may proceed.

Mr. Henderson. I have already filed, with the committee, a statement of what I have to say.

Senator Donnell. Pardon me, Mr. Henderson. You filed your statement?

Mr. Henderson. Yes.

Senator Donnell. I don't find it. Mr. Biemiller's has been filed.

Mr. Henderson. I filed one, I believe, 2 days ago in accordance with the new principles.

Senator Donnell. I am not questioning your having done so. I would like to have a copy of it.

STATEMENT OF LEON HENDERSON, CHAIRMAN, EXECUTIVE COMMITTEE, AMERICANS FOR DEMOCRATIC ACTION

Mr. Henderson. Mr. Chairman, I would like to register as chairman of the executive commitee of Americans for Democratic Action our objection to S. 545. I just briefly state our philosophical objections to it and Mr. Biemiller will take up any particular objections.

In the last analysis, Americans for Democratic Action is against this bill because it places Federal health aid on a charity basis. It is a medical dole. It substitutes the principle of the bread line for the principle of social security. It asks the taxpayer to provide an inadequate subsidy for the low-income groups, instead of giving all Americans, rich and poor, healthy and sick, the opportunity to share the expense and the benefits of medical care on a democratic basis.

It is a political sop to the demand for a better medical system. It will frustrate the possibility of achieving a democratic public-health-insurance system. Its obvious purpose is to give its sponsors a chance to say that they are for public health—without in any way giving the American people what they want and what they can have. It is a liberal mask for a reactionary policy.

It represents a school of thought which has a special affinity for doles and bread lines—for the "trickle down" theory of prosperity—for patching up the gaping sores of our economy by charity, while stifling the possibilities of full economic growth which we can achieve on the basis of democratic ideas.

I have stated what is the representative thinking of our groups as I have discussed it with them, and if there are any questions I will be glad to respond. If not, I am glad to present our member, Mr. Biemiller.

Senator **Donnell**. Do you have any questions?

Senator **Murray**. No; I don't, except I would like to inquire if you have had considerable experience with the problems and need of medical care in this country as a result of your previous positions here in Washington?

Mr. **Henderson**. Yes. One of my first, of course, was in connection with the committee on cost of medical care, I studied for the committee what low-income people had to do in the way of obtaining credit for desperately needed medical services. I was at that time with the Russell Sage Foundation. Then, through various governmental positions and particularly as an economist in the WPA I got to have a real knowledge of what the demands are and got the feeling very definitely that we should pass out of the charity period of taking care of things such as food and health and that it was a matter of extreme poverty at the national level if we did otherwise. It is for that reason I have my general opinion of any bill which is not based on the broad principles of insurance for health.

Senator **Murray**. As an economist in the WPA you learned, I assume, of the vast number of people in the country who were unable to support themselves?

Mr. **Henderson**. Yes. And one of the jobs that I had was to analyze the various reports of all kinds that were made by the WPA, not just reports in the field as to the members, but the special studies that were conducted.

Senator **Murray**. You made a special study of the lack of purchasing power?

Mr. **Henderson**. Yes.

Senator **Murray**. In the Nation during that period, and made considerable study of that subject?

Mr. **Henderson**. That is right.

Senator **Murray**. I guess that is all.

Senator **Donnell**. Mr. Henderson, you term S. 545 as a political sop?

Mr. **Henderson**. Yes, sir; that is what I think it is.

Senator **Donnell**. You do not give the framers of that bill credit for having attempted to solve this problem to the best of their ability and sincerity?

Mr. **Henderson**. Senator——

Senator **Donnell**. Is that correct?

Mr. **Henderson**. I am familiar with the ability of some of the framers and I wouldn't say not to the best of their ability.

Senator **Donnell**. You think their ability is very limited?

Mr. **Henderson**. I think they have ability but I believe what I say. This is an attempt to head off a real demand on the part of the country for a wide national health-insurance plan, and I believe that the results of examination of boys being inducted for drafts show that there is need for something more than is provided by this bill for the general improvement of health. I believe that on an insurance basis we can have——

Senator DONNELL. Mr. Henderson, what is the real purpose for organization of Americans for Democratic Action? Why did that happen to come into existence March 29?

Mr. HENDERSON. It dates back, Senator, to the early part of last summer when James Loeb was Secretary of the UDA. He began talking with other groups—labor groups, social groups, legal groups—about forming a more perfect union of liberals, I would say. One of the reasons for the canvass was the fact that many labor organizations had become perverted and distorted by outside discipline and communistic activity. As a result of this canvass of people, a conference took place. We came together on January 5 and formed a temporary organization, and then on March 29 and 30 we established a constitution and elected officers.

Senator DONNELL. At the January 5 conference—in the first place where was that held?

Mr. HENDERSON. Held in Washington.

Senator DONNELL. How large an attendance was it?

Mr. HENDERSON. It was probably 110 but a lot of people would have liked to come. I might say that at that time I was still chairman of the national independent committee which is the old Norris-LaGuardia committee, which had been in existence for quite a long time and Mr. Loeb approached me in that connection.

Senator DONNELL. In what building in Washington was that meeting held on January 5?

Mr. HENDERSON. It was held at the Willard Hotel.

Senator DONNELL. It was held at the Willard Hotel?

Mr. HENDERSON. Yes, sir.

Senator DONNELL. And was Mr. Wilson Wyatt present at that time?

Mr. HENDERSON. Mr. Wilson Wyatt, Mrs. Eleanor Roosevelt were present—practically all the people, as I recall, that appear as officers and members of the board were present. I will be glad to supply a much longer list of those that attended, Senator. I am very proud of it. I think it is the blue-ribbon list of noncommunistic liberals.

Senator DONNELL. Noncommunistic liberals?

Mr. HENDERSON. Yes.

Senator DONNELL. You were of the opinion, were you, that some of the liberal organizations were becoming communistically inclined, and the purpose of this new organization was to avoid that communistic tendency; is that correct?

Mr. HENDERSON. That wasn't the purpose.

Senator DONNELL. What was the purpose?

Mr. HENDERSON. The purpose as stated—I read that to you in the beginning. We just collected together on the principle that we would not admit people of totalitarian beliefs. That was our main reason for coming together—liberals who were trying to find better means of organization—and it was felt that definite need existed for the organization of liberal opinions. And the happenings since that time have certainly borne out that fact. I think we got started a little late. I wish we had started earlier.

Senator DONNELL. What other legislation has this organization interested itself in?

Mr. HENDERSON. It has interested itself in the FEPC.

Senator DONNELL. You had a witness testify here on that subject, did you not?

Mr. HENDERSON. Mayor Humphrey, of Minneapolis. We are tremendously interested in plans to either head off or mitigate the effects of a business recession and to that end we prepared a very careful statement of our views of what ought to be done. It was a report on economic stabilization and, as a result, we have been invited to appear before Senator Taft's Joint Committee on the Economic Report on July 16. We have taken an active part at any time that we could to get our 2 cents' worth in. We opposed the Taft-Hartley bill and opposed it to the fullest strength that we had at the time. I would say, Senator, we are, to the extent of our limited resources, human and otherwise, we are taking part at every point we can to present the liberal point of view on legislation.

Senator DONNELL. Are there any other specific legislative acts that you have appeared either for or against—that is, your organization—except those you have mentioned?

Mr. HENDERSON. I don't believe so insofar as appearances before committees are concerned.

Senator DONNELL. I think that is all unless Senator Murray has something.

Mr. HENDERSON. Might I then with your permission present as the ADA witness, Mr. Andrew J. Biemiller, former Member of Congress from the Fifth District of Wisconsin.

Senator MURRAY. Before he takes the stand, I would like to ask, What do you think is the cause for people in this country tending to espouse totalitarian proposals?

Mr. HENDERSON. Senator, there are many reasons, not the least of which is there hasn't been a strong aggressive support on the liberal left for causes of poor people and the people that are underprivileged. There is the fact that every day on some front the Communist Party for its own reasons—cruel reasons many, many times—is the active proponent of what seems to be liberal legislation.

Senator MURRAY. Mr. Henderson, I find a tendency on the part of the majority party, here to regard the so-called New Deal as something inimical to the best of interest of the welfare of our country. They seem to have the idea here that anyone who has ever had any connection with the New Deal should be eliminated from the Government service and should not have any voice in Washington at all. Do you approve of that?

Mr. HENDERSON. No. I don't think that because you labored in the vineyard you ought to get a second-class citizenship. I have noticed that tendency that you have spoken about. It is not entirely in the majority party though, Senator. I think you find that "down on the Avenue" that tends to take place, also. But I think the only way to test that out is not in the committee room.

Senator MURRAY. Do you know of legislation that the New Deal advocated and put into effect that was improper and should be repealed?

Mr. HENDERSON. No; I don't know of any that ought to be repealed. I can see improvement from time to time. Advancement in social security—that coverage needs to be broadened and the benefits have got to be more in step with the cost of living.

Senator MURRAY. Right from the commencement of the New Deal, at least shortly after the New Deal administration went into power here and things began to improve, there was immediate effort to discredit the New Deal. I remember in 1938—'37 and '38—you took a great interest in the causes of the recession at that time, and some of the leaders of industry and business in this country had taken the attitude that the New Deal was all wrong and that it had produced a dangerous condition in our country. They were criticized, for instance, for such measures as the Securities Exchange Commission, the Federal deposit insurance system, and many other measures that were brought out at that time.

I remember we had a hearing here in 1938 to study the causes of recession, and representatives of big business came down here and complained that the recession was due to the fact that the New Deal had created a fog of fear and uncertainty in the country, and that businessmen and industrialists were afraid to invest their money any more, and that was the cause of recession, and they thought that the New Deal should be eliminated. You don't approve of that kind of attitude, do you?

Mr. HENDERSON. No; I certainly don't. I spent quite a bit of my time opposing it, as you know.

Senator MURRAY. You think the trouble in the country has been they have not given enough consideration to the need for bettering the conditions of the masses of our people?

Mr. HENDERSON. I am sure about that, Senator, and as I said here in my statement as to this legislation, I have the decided feeling that we can accomplish two great stabilizing activities by the expansion of social services of all kinds, one where you give real attention to the lower income people. You can provide for a general lift in the standard of living such as you couldn't accomplish in 50 years otherwise by economic means, that is, by broader welfare legislation.

And the second thing, I believe as far as maintaining a steady stream of purchasing power and taking the fear out of people's hearts that keeps them from buying—from buying homes and trying to improve the conditions by buying of automobiles and things like that—that you get a broad fortification of consumer purchasing power through a broader social activity. You accomplish two purposes that way. And when justice and economics come into understanding, I think you have the happiest of American principles.

Senator MURRAY. And that is the best defense against communism in this country?

Mr. HENDERSON. Oh, yes. The Communists can't make any headway in this country as long as economic conditions are fairly well maintained.

Senator DONNELL. Have you, Mr. Henderson, studied the operation of compulsory insurance in other nations?

Mr. HENDERSON. No.

Senator DONNELL. You have not?

Mr. HENDERSON. I have kept track of this, of course, in a general way, as I said. I installed the first State employees' retirement system in Pennsylvania a number of years ago.

Senator DONNELL. That isn't health insurance. I am asking you whether you have made any study of the operation of compulsory health insurance in any other nation?

Mr. **Henderson**. No; but Mr. Biemiller intends to refer to it.

Mr. Biemiller is presently acting political director of Americans for Democratic Action. He has long experience with the legislative battle for a health-insurance program, both as a member of the Wisconsin State Legislature from 1937 to 1941 and in Congress from 1944 to 1946.

Senator **Donnell**. Will you state your name and your connection?

(The brief submitted by Mr. Henderson follows:)

Mr. **Henderson**. My name is Leon Henderson. I am appearing before this committee on behalf of Americans for Democratic Action. I am chairman of the executive committee of the ADA. I have here a statement of the principles and aims of the ADA, as well as a list of our national officers which I would like to submit for the record.

Since the time allotted to ADA is short and since our main witness is former Congressman Andrew J. Biemiller, I will make my remarks brief.

I am not an expert nor a technician in the field of health legislation. I would like, however, to present in general terms the position of the ADA on the bills before your committee.

ADA is against the so-called health bill, S. 545. ADA stands for an expansion of the social-security system to provide medical care to all the people as a right rather than a charity.

At the convention which formally created our organization in March of this year, we adopted a statement of principles which reads, with reference to health legislation, "We also urge a Federal system of health insurance, Federal aid for expansion of health centers and other medical facilities, with the widest possible use of wartime medical discoveries and Government support of medical research in special fields."

ADA believes that the social-security method of meeting the health needs of the people provides an assurance to the individual of certain rights regardless of politics, color, or religion. We believe that a national-health insurance program is the only democratic way to meet the health requirements of the Nation. We also believe it is the most economically feasible.

I have had the bitter experience of seeing political football played with the attempt to protect American workers, farmers, and businessmen from the effects of inflation. But I never, even at the peak of the struggle to preserve price controls, would have believed that the health of our people would be made an instrument for partisan politics.

Speaking as a former Government administrator and as a private citizen intensely interested in good government practice, it seems inescapable to me that S. 545 sets up a system which will require innumerable investigators, many of whom may be political appointees. S. 545 proposes a $200,000,000 Federal grant to be matched by the States to be administered according to a "charity" formula.

Under the Taft bill the money for medical care cannot be spent to meet medical need until the plea for charity has been made and accepted. To accept a plea for charity will require investigation. Investigation requires investigators and investigator means people who have to be appointed and then paid. Under S. 545, these jobs are in the hands of the States and there is no provision to protect the people from having them used for patronage purposes.

A good investigator cannot possibly investigate more than 50 cases a day. If this bill is to assist 20 percent of the population, as Senator Taft has estimated, this committee can do the arithmetic on the number of investigators who will be needed. I figure it will mean between 600,000 to 1,200,000 man-days of investigators's time to administer the bill.

Under S. 545 the whims, personal prejudices, and political loyalties of the investigators "may" determine who secures doctors' care. Under the proposed national health-insurance program the rules of the game are established in the basic legislation. There is no investigation into the private affairs of our citizens. People secure rights, not charity to be determined at some future date by investigators as yet unnamed, the number undetermined.

There is one other feature of Senator Taft's bill that deserves comment.

The Senator's bill lays the ground work for legalizing an economic monopoly of organized medicine under officials of the AMA and its affiliates.

This issue of economic freedom of course is the basic cleavage between the economic philosophy of Senator Taft and his supporters and the ADA. We believe that the economic freedoms of consumer choice, of investment—the economic freedom of individual and collective enterprise—are endangered by the growth of monopoly.

I believe that doctors should have absolute control in the realm of medical decisions and I believe that they along with other professionals have every right to demand and secure remuneration in accordance with their investment of time and money in acquiring their professional skills. But I am opposed to the doctors' building an airtight monopolistic control over the economics of medicine which is the people's business as well as the doctor's.

S. 545 provides that a State "may" designate a prepayment program as the vehicle to receive funds and administer the joint State and Federal health program. This means that a State "may," if the State affiliate of the AMA is strong enough, designate the medical society insurance program as the instrument to receive Federal and State funds.

These medical society prepayment plans have been organized primarily for a political purpose: to ward off a national health-insurance program. They were not organized to make better care available at lower cost. They are the esence of monopoly. The subscriber-patient has absolutely no voice in determining policies, scope, and extent of service, or method of payment. Control rests in the hands of a small clique who in State after State duplicate all or in part the board and officers of the State societies. Control of the people's money, its collection and distribution, rests in the hands of this small group of doctors. Senator Taft leaves the way open in his bill for Federal funds and State funds to be administered in the same way by this small monopolistic group.

This monopoly issue has nothing to do with the practice of medicine. This issue of monopoly is important for it has to do with the lifeblood of democracy: control of the economics of what now is a 3 to 4 billion-dollar industry—a big business.

STATEMENT OF HON. ANDREW J. BIEMILLER, ACTING POLITICAL DIRECTOR FOR THE AMERICANS FOR DEMOCRATIC ACTION

Mr. BIEMILLER. Andrew J. Biemiller. My residence is Milwaukee, Wis. I am acting political director for the Americans for Democratic Action.

Senator DONNELL. What is "political director," as you use that term?

Mr. BIEMILLER. I will be concerned primarily with developing techniques for the election of good, honest liberals and in all possible ways to make their campaigns successful.

Senator DONNELL. Are you on the salary roll of the Americans for Democratic Action?

Mr. BIEMILLER. I am at the present time.

Senator DONNELL. Would you mind telling us what your salary is?

Mr. BIEMILLER. It hasn't been decided.

Senator DONNELL. That detail is to be worked out, but you expect to be compensated?

Mr. BIEMILLER. Yes, indeed.

Senator DONNELL. How long have you been acting political director?

Mr. BIEMILLER. For about the last 10 days.

Senator DONNELL. Mr. Biemiller, have you studied the operation of compulsory health insurance in other nations?

Mr. BIEMILLER. I have, sir.

Senator DONNELL. Have you been in other countries and made a personal study of it?

Mr. BIEMILLER. I haven't.

Senator DONNELL. You haven't been in any other country that has compulsory health insurance?

Mr. BIEMILLER. No; I have not.

Senator DONNELL. What particular study have you given, shall we say, to Great Britain?

Mr. BIEMILLER. My original work comes from my graduate studies at the University of Pennsylvania under Dr. Edward P. Cheyney. That was back in the 1920s when I specialized in the social and economic history of nineteenth and twentieth century England. At that time I was particularly concerned with the development of the health-insurance system of England.

Senator DONNELL. What books did you study that took up the subject of health insurance in Great Britain?

Mr. BIEMILLER. Among other things I read the entire debate in the Commons on the question as it developed over the years in England, particularly in connection with the great Lloyd George program early in the twentieth century. Since that time I have kept in full touch with the subject and I have read most of the literature in the field. I am quite familiar with it.

Senator DONNELL. Can you tell me the names of two or three books?

Mr. BIEMILLER. Of course. One of the books that I have enjoyed reading very much and indirectly I was responsible for it being written, was the late George Crownhart on health insurance abroad. He made that study for the State society when I introduced some legislation in the Wisconsin Legislature.

Senator DONNELL. Is that J. G. Crownhart?

Mr. BIEMILLER. That is right.

Senator DONNELL. Secretary of the State medical society?

Mr. BIEMILLER. He is now deceased.

Senator DONNELL. But the book to which you refer, the one entitled "Sickness Insurance in Europe"?

Mr. BIEMILLER. That is one of the books.

Senator DONNELL. You are familiar with some of his conclusions in that works?

Mr. BIEMILLER. I am familiar with most of his conclusions. I have debated them, as you know, with Mr. Crownhart many times in Wisconsin.

Senator DONNELL. He takes views contrary to your own as to the advisability of compulsory health insurance?

Mr. BIEMILLER. That is correct.

Senator DONNELL. You say you assisted in the preparation of his book?

Mr. BIEMILLER. No; I stated that indirectly I was responsible for the book being written. After I had introduced some legislation in the Wisconsin State Legislature, the State medical society put on a special assessment and subsidized Mr. Crownhart's study in European countries. As secretary of the State medical society, he was the spokesman for organized medicine.

Senator DONNELL. What was the general stand as regarding the advisability and knowledge of the subject?

Mr. BIEMILLER. I don't think anyone would question the general competence of Mr. Crownhart as a medical society spokesman. I have discussed this subject both publicly and privately with him.

Senator DONNELL. Do you regard the book to which you have referred, Sickness Insurance in Europe, by Crownhart, as in the nature of what Mr. Henderson has characterized S. 545—a political sop?

Mr. BIEMILLER. I don't see that that phrase has any connection with his book. It was a fairly well-done special pleading in defense of organized medicine.

Senator DONNELL. Did it represent his opinions on the subject, do you think?

Mr. BIEMILLER. Correct.

Senator DONNELL. You regard Mr. Crownhart as a man of integrity and of excellent experience and high standing in the State?

Mr. BIEMILLER. And particularly as an excellent special pleader for the interests that he represented.

Senator DONNELL. I wasn't asking you that. I was asking you what was his standing among the people of the State—whether he stood very high or not?

Mr. BIEMILLER. In a great many aspects he stood very high; no question about it.

Senator DONNELL. No question about his ability?

Mr. BIEMILLER. No.

Senator DONNELL. Mr. Henderson was very specific in designating S. 545 as a political sop. Now, I want also, to go back for a minute to this book by Mr. Crownhart and ask you whether or not as far as you know it was put out back in 1938 by Mr. Crownhart as a political sop; do you think it was?

Mr. BIEMILLER. I think it was very definitely a political volume in an attempt to counteract the growing demand for compulsory health insurance.

Senator DONNELL. You think he put it out to express the views of the State medical society?

Mr. BIEMILLER. The book has been so regarded in Wisconsin—as the official statement of the views of the State medical society.

Senator DONNELL. It represents the views of the State medical society?

Mr. BIEMILLER. Yes.

Senator DONNELL. Mr. Biemiller, what other studies have you given personally to compulsory health insurance?

Mr. BIEMILLER. Well, as I said, I have read the majority of the books in the field. I am familiar with the work of Dr. Millis at the University of Chicago, for example, and with Dr. Falk's works and Dr. Sinai's works. I have read the various periodicals in the field that have appeared from time to time. I know Dr. Reed's works.

Senator DONNELL. Is that Dr. Lewis Reed?

Mr. BIEMILLER. Yes.

Senator DONNELL. You are quite familiar with both Dr. Falk and Dr. Reed?

Mr. BIEMILLER. I believe I have met Dr. Reed once. I have probably discussed the problem with Dr. Falk a half a dozen times.

Senator DONNELL. All right. Have you studied the experiences in New Zealand?

Mr. BIEMILLER. I have studied the experiences in New Zealand and had the privilege of spending an entire afternoon with the Premier of New Zealand when he was here and discussed the subject with him.

Senator DONNELL. Have you studied the experiences in France and Germany?

Mr. BIEMILLER. I am more familiar with the German experiences than I am with the French.

Senator DONNELL. That is all; go ahead.

Mr. BIEMILLER. I am appearing here today on behalf of Americans for Democratic Action in opposition to S. 545 and in favor of S. 1320.

For the record, I would like to read paragraphs (b) and (c) of section 2 of S. 545:

> (b) That there are inadequacies in the distribution of public health services and of medical and dental services in the United States, with the result that some persons are unable to secure adequate health and medical services.
>
> (c) That it is the policy of the United States to aid the States through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual, regardless of race or economic status.

We do not quarrel with these objectives of S. 545. They are good objectives. But S. 545 will not accomplish those objectives. To the extent that the sponsors of S. 545 are able to convince the American people that these objectives will be accomplished by the bill, they are guilty of perpetrating a political fraud on the American people. S. 545 is an expression of the present political and economic desires of the American Medical Association. I think I can sum up these objectives of the AMA which have been put into legislative form by the sponsors of S. 545 as being—

(1) The continuation and maintenance of the charity methods of paying for medical care for low-income people.

(2) Underwriting, with Federal funds, the present method of paying for medical care.

(3) Entrenching doctor control of public funds.

(4) Using Federal and State money to underwrite existing doctor-controlled prepayment plans.

Mr. Henderson has stated our basic objection to the charity way of paying for medical care for low-income people. What we want to make clear is the fact that we object to the present charity method of meeting medical need for the low-income group. A charity program is the most costly way of meeting medical need for this group if it is considered apart from the rest of the population.

If the Congress is to appropriate money for medical care, it should be used for that purpose with the lowest possible minimum amount spent in administration. But a public charity program financed by Federal and State funds, if it is to meet the need of 20 percent of our population, or approximately 30,000,000 people—the figure used by Senator Taft—is going to mean an absolutely fantastic administrative bureaucracy, devoted mainly to prying into the personal affairs of our citizens. If there are not to be investigations, then it means that the sponsors of this bill are willing to see the people's money spent without any controls. I am sure that the Congress would not consent to such uncontrolled expenditures even at the request of the American Medical Association.

I hope when the facts are known that the Taft bill will be labeled not only as a charity bill, but as a bill establishing a well-financed system of political medicine.

What do I mean by political medicine?

Since S. 545 in no way establishes standards and civil-service protection for those who must do the investigation and administration of the program, the money involved is likely to become a political "kitty" used by State political machines to pad State pay rolls. If the sponsors of S. 545 are serious in their sponsorship of this bill, then they at least should establish the kinds of standards that will make it impossible for this Federal money to be used for patronage purposes in the States.

We vigorously oppose the provision contained in section 101 (c) requiring that the Administrator be a doctor of medicine and the provision contained in section 104 (c) requiring that there shall be a Director of the Office of Medical and Hospital Care who shall also be a doctor and shall have had 5 years of active practice.

Any program designed to benefit people should, in our estimation, be run by the people, or designated representatives, who have the welfare of the general public at heart. To place the administration of the program outlined in S. 545 in the hands of a doctor would actually mean placing the policy decisions in the hands of the A. M. A. Since the authors of S. 545 have followed the dictates of the A. M. A. in writing this bill, it would appear they are willing to see the A. M. A. medical monopoly administer this program. No self-interest group, least of all the American Medical Association, which has bitterly opposed the establishment of a real health program, should be vested with complete and final authority as is proposed in this bill.

The Congress does not require, and would certainly oppose a requirement that the Secretary of Labor be a member of a union; or that the Secretary of Agriculture be a member of the Farm Bureau or the Grange. Why should Congress require that a doctor administer the health program?

Though Mr. Henderson has stated our belief that this bill contains in it monopolistic implications in regard to the doctor-operated prepayment plans, I want to elaborate slightly on the provision in question. Section 712 (a) (4) provides on page 18, lines 13–14, that the State may make payments to any voluntary nonprofit insurance fund. The bill does not stipulate, as does S. 1320 in section 217 (c), that no single plan can have exclusive right to administer the benefits.

This section—section 712 (a) (4)—does not provide any protection for the money that may be turned over to the States to pay premiums or partial premiums for low-income people who are brought in under this plan. Under this section a plan may have an exorbitant administrative cost so that a major part of the tax money turned over to the plan would be used for administrative expenses rather than doctors' care. Or the plan may have a high premium for exceedingly low benefits. There is absolutely no protection afforded the Federal taxpayer under this section, nor is there any assurance that the patient would receive the comprehensive care that he is led to believe he would receive.

This program of S. 545 would actually mean that if all, or a substantial portion, of charity care were given through existing doctor-controlled prepayment plans. there would be a lowering of both the quantity and quality of care available. Charity care today, even at its worst, does tend to be fairly comprehensive—at least more so than most of the doctor-run prepayment programs. Likewise, charity care—at least in the bigger cities—tends to be fairly high-quality care. We believe that even most of this quality would be lost for this group in the population if they were forced to join a doctor-run prepayment plan to secure that care.

I am not at all surprised that the one point that the A. M. A. and its constituent State and local units all agree on in supporting this bill is the further entrenching of a medical bureaucracy dominated and controlled by persons of their own choosing. This is typical of how the A. M. A. works. The organized medical profession has always fought progressive health legislation designed to assure more adequate and more democratic organization of medical services in this country. They fight right up to the time where it looks like a program has popular support and then they try to grab control. Let me illustrate by our actual experience in the State of Wisconsin.

In Wisconsin the State medical society for years fought all attempts to set up voluntary health-insurance plans. Finally, in 1945, realizing that the public demand for health insurance was growing so rapidly that the demand could no longer be ignored, the Wisconsin Medical Society introduced and passed in the State legislature a bill commonly known as the Medical Fence Act.

Senator Donnell. You say it is "commonly"?

Mr. Biemiller. Correct.

Senator Donnell. Who started that title of that bill?

Mr. Biemiller. I couldn't say exactly, but I remember that the phrase begun to appear on the floor of the legislature and it appeared in two of the leading newspapers of the State—the Milwaukee Journal and the Capital Times in Madison, Wis. That is the way it is commonly referred to—the Medical Fence Act.

This bill sets up a monopoly for the State medical society over all voluntary health-insurance plans. Attempts to amend it to grant permission to cooperatives or unions or any association of citizens or county medical societies to formulate their own plans were beaten down.

The Milwaukee County Medical Society has started a relatively good surgical-care plan. The State society has insisted that this plan be merged with their own inadequate one. Recently the American Medical Society has ruled that the Milwaukee plan must be merged with the State plan.

Incidentally, it is worth noting that spokesmen for both the State and county medical societies have publicly admitted that their plans were initiated only in efforts to ward off compulsory health insurance plans.

Also to keep the record straight it should be noted that in this session of the legislature the Wisconsin State Medical Society originally opposed an enabling act for cooperative health associations. However, recognizing that this bill had the militant support of the powerful cooperative and the union movements of our State, the State medical society agreed to a compromise bill which embodied all of the basic premises of the original bill. This bill has passed both houses of the legislature by unanimous vote.

The A. M. A. itself through its bureau of medical economics in 1938 has stated the case against the kind of medical care organization proposed by S. 545, and has stated very ably the case for S. 1320.

In a bulletin entitled "A Critical Analysis of Sickness," they said:

> Without some form of compulsion, voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population with even approximate fairness. The young and healthy will not join and the aged and sickly, if accepted, will raise the cost to a prohibitive point and, if rejected, remove protection from those most in need.
>
> Sickness insurance cannot distribute the burden of sickness among the low-income classes unless it is compulsory.

The bulletin goes on to point out that many so-called voluntary schemes have had to resort to indirect methods of compulsion, such as making membership in a voluntary plan a condition of employment, and so forth.

It then continues to say:

> * * * that all such indirect compulsion finally proves ineffective. * * *

It uses as an example Denmark, which was once "hailed by defenders of the voluntary system" as a model and which finally adopted a thoroughgoing compulsory system in 1933.

I think that we are at the stage of some of the European countries such as Denmark, who now have adopted a compulsory system. The A. M. A. says voluntary plans cannot be made comprehensive; cooperative plans know that they have to fight continually for their existence. The Taft bill essentially recognizes this principle and would use Federal and State money to finance premium costs of low-income people so they can secure medical service through doctor-owned plans. Essentially, this is a form of compulsion which the A. M. A. recognizes will broaden the risk base and the financial resources, of their programs.

Though it has been said before, I desire to repeat the basis for our support of a social-security system of payment for medical care. We believe that it is an approach that preserves the respect of the individual, and freedom of consumers' choice. This, the A. D. A. believes to be important in the face of increasing trends toward the denial of individual rights in those parts of the world under Communist domination and influence. We believe that the social-security principle is financially sound, for it removes the whole administration of the medical-care program from the arena of partisan politics.

S. 1320 does provide for local, State, and community control in those aspects of the program that are important. Rightly enough, it sets up Federal standards, but within the framework of these Federal standards, provision is made for local administration.

Unlike S. 545, the National Health Insurance and Public Health Act gives real recognition to the voluntary-service plan. It does provide for experimentation with various types of medical service which S. 545 does not do. S. 1320 would stimulate the establishment of new plans under the democratic control of local people selected by the families in the plan. In this way, the bill not only guarantees free choice of doctor, but free choice of plan. Since the program will not be burdened with any army of investigators as compared with S. 545, it will keep administrative personnel and administrative costs to a minimum.

S. 1320 protects the integrity of the medical profession and permits the professional man to exercise his best judgment in professional matters by removing economic barriers to medical care.

S. 1320, since it provides for three types of payment—capitation, fee-for-service, and salary—provides for experimentation into the best method of payment of doctors in order to secure the most adequate type of medical care.

Many scare words have been raised in the last few years about the question of what should be done by the Federal Government to provide medical care for the people. It is time that the problem be considered for what it really is, not a problem of medicine but a problem of social and economic organization.

It is not a question of whether American doctors have done a good job, or whether American medicine has made wonderful progress over the years. It is a question of how the best of American medical science can be given to the greatest number of people, in the most economic way, in conformity with our American traditions of freedom. We believe that S. 1320 will accomplish these goals.

Senator DONNELL. I would like to ask you a few questions. I noticed near the conclusion of your statement you say:

> It is not a question of whether American doctors have done a good job or whether American medicine has made wonderful progress over the years.

Do you mean to imply by that statement American doctors have done a good job and American medicine has made wonderful progress over the years?

Mr. BIEMILLER. I have the greatest respect for the scientific advances made by American doctors and American medicine.

Senator DONNELL. You join in the view that American doctors have done a good job and American medicine has made wonderful progress over the years?

Mr. BIEMILLER. They have made tremendous progress, without any question.

Senator DONNELL. And it has been done where there has been no compulsory health insurance; is that correct or isn't it?

Mr. BIEMILLER. It is perfectly proper to note that this progress has been made without a system of compulsory health insurance, but I do believe that the major fact which should be noted is that most of the research leading to advances in medical science has been done by salaried doctors on Federal or State pay rolls or by those working for foundations.

Senator DONNELL. Mr. Biemiller, the American doctors themselves, one hundred and forty or one hundred and fifty thousand, generally speaking, are out practicing their profession, are they not?

Mr. BIEMILLER. Certainly.

Senator DONNELL. You are agreed, are you not, they have done a good job?

Mr. BIEMILLER. I think they have been limited by the fee-for-service system but considering the burdens which the inadequate incomes of large groups of our population placed upon the doctors, they have done a good job.

Senator DONNELL. Yes. By your statement here—

> It is not a question of whether American doctors have done a good job, or whether American medicine has made wonderful progress over the years.

I understand that you are indicating you are not questioning those facts at all?

Mr. BIEMILLER. Not for a moment. What I am saying further, Senator, is that I don't think the scientific advancement of medicine has any connection pro or con with the discussion of compulsory health insurance, as some of the opponents of compulsory health insurance have attempted to prove.

Senator DONNELL. Crownhart, for instance, did he concur with your views in that connection?

Mr. BIEMILLER. No. I wouldn't expect Mr. Crownhart to concur in my views.

Senator DONNELL. He took a position contrary to yours; is that correct?

Mr. BIEMILER. Quite so.

Senator DONNELL. Mr. Biemiller, you served in the Legislature of Wisconsin, did you not?

Mr. BIEMILLER. Three terms.

Senator DONNELL. You were a party floor leader for the Democrats?

Mr. BIEMILLER. Progressive floor leader.

Senator DONNELL. You are a Democrat, are you not?

Mr. BIEMILLER. I was at that time a Progressive.

Senator DONNELL. When did you change over to the Democrats?

Mr. BIEMILLER. I served three terms as a member of the Progressive Party. I broke with the leaders of the Progressive Party on the war issue in 1940 and '41 and joined the Democratic Party.

Senator DONNELL. You were elected to Congress here in 1944?

Mr. BIEMILLER. Yes.

Senator DONNELL. On the Democratic ticket?

Mr. BIEMILLER. Correct.

Senator DONNELL. Did you run for reelection in 1946?

Mr. BIEMILLER. I ran for reelection, but the unfortunate landslide of '46 eliminated me from the Congress.

Senator DONNELL. Consequently, you are not in Congress?

Mr. BIEMILLER. I am not a Member of Congress.

Senator DONNELL. That leaves no reflection. I just wanted to get the facts. You have had various legislative experiences and now you are what—what is that title?

Mr. BIEMILLER. Acting political director of the Americans for Democratic Action.

Senator DONNELL. How large an organization is this Americans for Democratic Action?

Mr. BIEMILLER. I believe that Mr. Henderson testified on that matter and is more competent to testify than I am, for, as I stated, it was only a few days ago that I joined the ADA staff, and I am not familiar with the organizational details.

Senator DONNELL. Mr. Biemiller, I observe from your statement that you are very much opposed to some of the activities of the American Medical Association; is that correct?

Mr. BIEMILLER. I am opposed to—may I state it this way? I believe that the American Medical Association has perpetrated a grievous error in objecting to compulsory health insurance at the present time. I feel that we should expect the doctors to solve the problems of medical economics. As I stated earlier, in Wisconsin and also throughout the Nation, as I have spoken on the public platform with leaders of the American Medical Association and county medical societies, they have stated rather flatly that the only reason they are interested in voluntary health insurance plans is in an effort to ward off compulsory health insurance. I think that is a grievous error on the part of the American Medical Association. I think actually what is happening is that large sections of our population—and I speak with some feeling on this because I have many people come in to talk to me—is that large sections of our population, unfortunately, are losing their faith in the medical profession because of its opposition to compulsory health insurance programs.

Senator DONNELL. As I was saying in my question, you are opposed to certain activities of the American Medical Association?

Mr. BIEMILLER. Yes.

Senator DONNELL. You have outlined your views as to what you are opposed.

Mr. BIEMILLER. I am opposed to their view, but I, of course, believe that the American Medical Association has a perfect right to state its views.

Senator DONNELL. Generally you are opposed to their views?

Mr. BIEMILLER. Yes.

Senator DONNELL. You know, as a matter of fact, that the American Medical Association consists of 130,000 or more of the physicians of this country, do you not?

Mr. BIEMILLER. Approximately that figure.

Senator DONNELL. That constitutes by far the greater percentage of doctors in this country—possibly 80 or 95 percent?

Mr. BIEMILLER. Approximately 90 percent, something like that.

Senator DONNELL. Would you say that approximately 90 percent of the doctors in this country are in the American Medical Association?

Mr. BIEMILLER. I wouldn't quarrel with that estimate.

Senator DONNELL. You think those gentlemen are making the mistake of their lives in the position they are taking?

Mr. BIEMILLER. Yes.

Senator DONNELL. You cited in your discussion this morning an effort on the part of the American Medical Association to fight against any progressive measure along the line of more democratic organization of medical service in this country. You say they fight right up to when it looks as though it might be progressive and then they try to grab control.

Mr. BIEMILLER. That has been illustrated by statements of other witnesses.

Senator DONNELL. Now, you refer to what you call there the Medical Fence Act. Isn't it a fact in the first place on that terminology that the Medical Fence Act is a term applied by proponents of the bill and is not the official name or generally accepted name of that bill in Wisconsin?

Mr. BIEMILLER. It is not the official name, but it is the generally accepted name as far as discussion of that act around the State.

Senator DONNELL. What does "fence" mean? Does that mean as a bar?

Mr. BIEMILLER. It is definitely to bar any group beside the State medical society from operating a voluntary insurance plan.

Senator DONNELL. You say this bill, this Medical Fence Act of 1945, as you termed it, sets up a monopoly for the State medical society over all voluntary health insurance plans. I have quoted you correctly, haven't I?

Mr. BIEMILLER. That is correct.

Senator DONNELL. That bill to which you refer is chapter 494 of the Laws of Wisconsin for 1945, is it not?

Mr. BIEMILLER. Yes.

Senator DONNELL. Approved July 19, 1945?

Mr. BIEMILLER. Correct.

Senator DONNELL. And that is the only bill to which you are referring when you say a monopoly has been set up for the State medical society over all voluntary health insurance plans?

Mr. BIEMILLER. That is right.

Senator DONNELL. So unless that bill sets up the monopoly there isn't any monopoly set up in Wisconsin?

Mr. BIEMILLER. You have got to refer to sections of that statute in connection with other sections of the statutes, too.

Senator DONNELL. Well, Mr. Biemiller, you say, and I am quoting from your statement:

> This bill sets up a monopoly for the State medical society over all voluntary health insurance plans.

Mr. BIEMILLER. Correct.

Senator DONNELL. Well, now, I have been unable to observe how your statement is justified. In the first place chapter 148 of the Statutes of Wisconsin for 1943—the statutes which is amended by this chapter 494 of the 1945 act, and chapter 148 is merely an act which continues the State medical society with general powers of a corporation. Now, as a matter of fact, Mr. Biemiller—you are a lawyer, aren't you?

Mr. BIEMILLER. I am not.

Senator DONNELL. Well, you know as a fact, do you not, that the only effect of chapter 494 is to insert additional powers that are granted to the corporation known as the State medical society? Isn't that correct?

Mr. BIEMILLER. Go ahead.

Senator DONNELL. Is that right?

Mr. BIEMILLER. No; it is not the only effect of it.

Senator DONNELL. Let's see what it is. Is there anything in chapter 494 of the 1945 act that says that nobody else can set up these voluntary health insurance plans, anything at all?

Mr. BIEMILLER. You are doubtless aware that under other statutes of the State of Wisconsin a corporation can't practice medicine.

Senator DONNELL. I am not talking about a corporation. I am asking you whether in your State this bill sets up a monopoly for the State medical society over all voluntary health insurance plans?

Mr. BIEMILLER. I don't see the correctness of your statement.

Senator DONNELL. I offer in the record a copy of chaper 494 which is nothing more than an analysis setting forth certain additional corporate powers of this particular society and nowhere does chapter 494 undertake to give a monopoly to anybody.

(The statute referred to follows:)

CHAPTER 494

AN ACT To renumber 148.01 (3) to be 148.01 (3) (a); to amend 148.01 (3) (a), as renumbered; and to create 148.01 (3) (b), (c), and (d) of the statutes, relating to sickness care by the State medical society

The people of the State of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 148.01 (3) of the statutes is renumbered 148.01 (3) (a) and amended to read:

148.01 (3) (a) The State society, or a county society in manner approved by the State society, * * * shall have the power to establish in the State or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low-income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

SEC. 2. 148.02 (3) (b), (c), and (d) of the statutes are created to read:

148.01 (3) (b) Such plan shall be exempt from the State insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness-care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association, or organization not a body corporate under said chapter.

Approved July 19, 1945.

Senator DONNELL. Isn't that a correct statement?

Mr. BIEMILLER. I do not agree with your interpretation. Here is the actual situation. That statute gave the State Medical Society—to this extent I agree with you—the right to set up its own corporation for a prepaid plan, but, likewise, the rest of the statutes of Wisconsin prohibit anybody else from so doing.

Senator DONNELL. What other statutes?

Mr. BIEMILLER. In Wisconsin, no corporation is permitted to practice medicine. I believe that is probably true in every State in the Union. Now, the effect of this has been that when the County Medical Society of Wisconsin desired to start a prepaid surgical-care plan, it was not able to do so legally. It is conducting one illegally at the present time. The county medical society attempted to amend the State law. We call it the Medical Fence Act, the legislative intent as made perfectly clear when it passed in 1945. One express purpose was to prohibit any other group from putting up a prepayment plan without the approval of the Wisconsin State Medical Society. Now, furthermore, as I pointed out in my document here, this year after considerable pressure was brought to bear, there has been passed a statute permitting cooperatives to engage in the practice of medicine—that is, special medical cooperatives. In 1945 when the cooperatives attempted to amend the pending legislation, which became the Medical Fence Act, the State Medical Society stepped in and stopped that from happening and the effect of the statutes of Wisconsin, as it stood at the end of 1945, was that no incorporated prepayment service plan could function in the State of Wisconsin. The doctors in the State Medical Society had succeeded in tying up those rights for themselves. That is the point I am making here.

Senator DONNELL. Mr. Biemiller, did I understand you to say something about the legislative intent? I take it we also agree that the effect of legislation speaks for itself in the language used therein. Do we not agree on that?

Mr. BIEMILLER. I have found that certain courts put out some pretty curious interpretations on the basis of legislative intent.

Senator DONNELL. If they were to put the interpretation you are talking about they would have to put some pretty strange language. There isn't one single thing in chapter 494 which you say in your statement here, and I quote it again—"sets up a monopoly for the State medical society over all voluntary health insurance plans." There isn't a single sentence or word in chapter 494 that undertakes to say that nobody else can set up such plan.

Now I offer for the record a copy of chapter 350 of the Laws of Wisconsin, approved August 9, 1935:

CHAPTER 350

AN ACT To create subsection (3) of section 148.01 of the statutes, relating to the powers of medical societies

The people of the State of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. A new subsection is added to section 148.01 of the statutes, to be numbered and to read: "148.01 (3) The State society, or a county society in manner approved by the State society, may undertake and coordinate all sickness care of indigents and low-income groups, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physician within such contracts shall be retained and that responsibility of physician to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient."

SEC. 2. This act shall take effect upon passage and publication.

Approved August 9, 1935.

I also offer from the Wisconsin Statutes, chapter 148 of the 1943 Wisconsin Statutes:

CHAPTER 148—MEDICAL SOCIETIES—148.01 STATE SOCIETY—148.02 COUNTY SOCIETIES

148.01 State society: (1) The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter, and enforce constitution, bylaws, and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the State society, whose decision shall be final.

(3) The State society, or a county society in manner approved by the State society, may understake and coordinate all sickness care of indigents and low income groups, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds and other means, provided only that free choice of physician within such contracts shall be retained and that responsibility of physician to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient (1935, c. 350).

148.02. County societies: (1) The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or Territories or of any foreign country, or who shall have received a license from the State board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than 15 adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (repealed by 1927, ch. 60, sec. 1).

And also chapter 148 as appears in the Statutes of Wisconsin for 1945.

CHAPTER 148—MEDICAL SOCIETIES—148.01 STATE SOCIETY—148.02 COUNTY SOCIETIES

148.01 State society: (1) The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the State society, whose decision shall be final.

(3) (*a*) The State society, or a county society in manner approved by the State society, shall have the power to establish in the State or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low-income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(*b*) Such plan shall be exempt from the State insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(*c*) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness-care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(*d*) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on July 26, 1945, nor to any contracts for the care of the indigent, nor shall any provision of charter 148 be construed to apply to any corporation, association, or organization not a body corporate under said chapter (1935 c. 350; 145 c. 494).

148.02. County societies. (1) The physicians and surgeons, not less than five in number of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or Territories or of any foreign county, or who shall have received a license from the State board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than 15 adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws, and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws, and regulations of the State society.

148.03 (repealed by 1927, ch. 60, sec. 1).

Senator DONNELL. Now, Mr. Biemiller, do you notice as a matter of fact that the issue in 1945 primarily was whether Cooperative plans should come in under the Medical Society Act or not, isn't that a fact?

Mr. BIEMILLER. I don't agree with that interpretation.

Senator DONNELL. You don't agree. Well, as a matter of fact what happened was that in 1945 the Medical Society succeeded in securing an amendment of its legislative charter and that amendment authorized it to go ahead with these plans that we are talking about. Now, this year of 1947 the Cooperatives have come in and successfully gotten the same thing for themselves, except, I believe that the Governor insofar as we know has not acted on the bill.

Mr. BIEMILLER. I haven't heard within the last few days.

Senator DONNELL. I haven't heard whether he has or has not. Mr. Biemiller, getting down to the merits of this bill, S. 545——

Mr. BIEMILLER. May I point out one more thing about the Wisconsin situation? May I remind you in 1945 the Milwaukee County Medical Society attempted to amend the State bill so far as to permit county plans to function in the State of Wisconsin. As late as the fall of 1946 the Wisconsin State Medical Society had taken steps to go into the courts and force the Milwaukee County Medical Society to abandon its plan. That is monopoly to my way of thinking. That problem was resolved by an agreement to arbitrate the differences between the Wisconsin State Medical Society and the Milwaukee County Medical Society and that arbitration, as I stated in my statement, has been resolved in favor of the State Society.

Senator DONNELL. Mr. Biemiller, referring to the experiences of Great Britain, do you remember the statement in Mr. Crownhart's book on page 64, which was taken from the director of one of the large public-health institutes in Denmark—you refer in your statement to Denmark. Let me just read you this and ask you whether or not you know of Denmark's experiences that would counteract this statement. This statement emanated from the director of one of the large public-health institutions in Denmark. This is taken from his works Sickness Insurance in Europe.

> "Sickness insurance is a leveling device," said this professor who had visited this country on occasion. "It assures the mediocre physician just about the same rewards as he would give an outstanding service if he were to have time. The incomes tend to be leveled, but that is not all; the tendency over the years is to

level the services to something that is neither bad nor good. But the incentive is gone, and we develop fewer brilliant minds in our teaching centers, and America captures the lead in health and methods to regain it."

In your observation in connection with sickness insurance, have you ever seen anything that contradicts what this professor, the head of one of the large public-health institutions, said? I have quoted from Sickness Insurance in Europe.

Mr. BIEMILLER. I will be glad to supply the committee with counterstatements from people who have studied the Danish situation, and there are opinions on the other side of the fence. I have read a great deal of literature in that field.

Senator DONNELL. Have you seen any statements on the Danish experiences to counteract this?

Mr. BIEMILLER. I have seen such statements.

Senator DONNELL. Can you tell me what they are?

Mr. BIEMILLER. I haven't got them handy. But I would be glad to furnish the committee with such statements.

Senator DONNELL. Will you mind doing that?

Mr. BIEMILLER. I will be glad to do so.

Senator DONNELL. As far as a comparison with respect to experiences in Denmark or any other countries, if you will.

Mr. BIEMILLER. I think, for example, if you will take the Orr book on England you will find some entirely different interpretations.

Senator DONNELL. Have you read the articles that appeared last year in the Christian Science Monitor on the experiences in New Zealand?

Mr. BIEMILLER. I have not read those articles.

Senator DONNELL. Have you read any works on New Zealand in the last year or so?

Mr. BIEMILLER. What I have read on New Zealand has been the official publications of the New Zealand Government, and, as I stated earlier in my statement, I spent an entire afternoon discussing the New Zealand experiences with Peter Fraser, the Premier of New Zealand, when he was here a year and a half or so ago.

Senator DONNELL. Have you ever heard of Dr. G. M. Smith, of New Zealand—anything about his authority?

Mr. BIEMILLER. I don't know anything about him.

Senator DONNELL. You couldn't pass on him to judge New Zealand?

Mr. BIEMILLER. No.

Senator DONNELL. Now, you referred to the organization for which you appear as one—I believe you or Mr. Henderson, or both, mentioned that it was in part formed, as I understood, to combat the tendency of communistic influences to prevail in liberal organizations; isn't that right?

Mr. BIEMILLER. I think the way I would state that is this, that the type of liberal Americans who are associated in the Americans for Democratic Action do not believe that those who espouse any form of totalitarianism can be counted upon as true liberals or allies of the liberal movement.

Senator DONNELL. Your organization, as I understand—you have only been with it about 10 days—was opposed to the labor legislation which was recently enacted. Do you think Congress was wrong on that?

Mr. BIEMILLER. Quite so.

Senator Donnell. Just as the American Medical Association is wrong on its position on health insurance?

Mr. Biemiller. Yes.

Senator Donnell. You are also advocating, I observe, a bill by Senator Murray with respect to the organization of the river valley authorities?

Mr. Biemiller. We feel very strongly, if we needed any further indication of the desirability of the Missouri Valley Authority, the present flood situation should convince anyone.

Senator Donnell. The flood situation is certainly most distressing; no question about that. It doesn't answer the question as to whether the suggestion of Senator Murray is appropriate?

Mr. Biemiller. I would add that we don't hear of any floods in the Tennessee Valley.

Senator Murray. Right there, isn't it a fact that it is one of the worst floods they have had for 103 years?

Mr. Biemiller. That is my understanding.

Senator Murray. If they have been trying to doctor this situation up there for 103 years and haven't made much progress, then you think the present system is a failure?

Mr. Biemiller. Quite so. I have also had the pleasure of three times visiting the Tennessee Valley Authority set-up, and I am convinced it is a fine institution, one that has brought great benefits to the American people and, incidentally, without which we would have had trouble developing atomic power during the war. I know of no valid argument against the Missouri Valley Authority.

Senator Murray. I think that covers that very well.

Senator Donnell. It doesn't quite cover it, sir. Mr. Biemiller, your organization advocates a great many things in this platform that thus far any Congress has not approved; is that correct?

Mr. Biemiller. Yes.

Senator Donnell. That is no reflection upon your organization or any reflection upon Congress.

Mr. Biemiller. If it weren't for the inactivity of Congress we wouldn't have a need for this organization.

Senator Donnell. As a matter of fact, you are getting right to the nail on the head, aren't you? The purpose of your organization is to advocate and work for the passage or development of legislation; is that right?

Mr. Biemiller. Yes; and the election of people who will help in the defeat or passage of legislation.

Senator Donnell. May I ask in that connection whether your organization considers itself to be under the La Follette-Monroney Act provision in regard to lobbying?

Mr. Biemiller. I would have to refer that to our legislative representative, Mr. David Lloyd.

Mr. Lloyd. We have registered under the pertinent statutes.

Senator Donnell. You are therefore an organization which is formed for the purpose of advocating and opposing legislation?

Mr. Biemiller. Quite obviously, sir.

Senator Donnell. There is no objection to that, but that is the purpose of your organization.

Senator MURRAY. Right there, isn't it a fact that every liberal and progressive piece of legislation that has been enacted in this country has been opposed by Congress at the start-off; isn't that true?

Mr. BIEMILLER. That is the general history of social legislation. Most reforms have started with a minority of the Congress backing them, and eventually the Congress has accepted them. I think, for example, if one looks back on, let us say, the proposal of Senator Robert M. La Follette, in the Republican National Convention of 1912, when he was practically tossed out of the Republican convention, we find that today most of those reforms have been adopted, almost all during the Roosevelt New Deal.

Senator DONNELL. Mr. Biemiller, how much actual study have you given in the last 10 years to the subject of compulsory health insurance? Have you actually in the last 10 years put in any considerable amount of study on that subject as to economic effect, as to the effect on medical practices, and as to the effect on the health of the people in the country affected?

Mr. BIEMILLER. Yes; I have done a good deal of studying on it. I can't give you an actual estimate of the number of hours, but there hasn't been a single month during the last 10 years that I haven't done some reading and investigating on the subject.

Senator DONNELL. What do you regard as the leading recent work on that subject; I mean to say, the most recent publication that you read as outstanding on compulsory health insurance?

Mr. BIEMILLER. I wouldn't want to pass judgment on that.

Senator DONNELL. Just name any 1 of 10, if you will, that you regard as among the leading works.

Mr. BIEMILLER. I regard the works of both Reed and Falk as excellent works.

Senator DONNELL. Dr. Falk and Dr. Reed, two of the three men who constituted a majority of the committee which drew up the platform of the National Health Association; you know that to be a fact, don't you?

Mr. BIEMILLER. I presume it to be.

Senator DONNELL. Of the American Public Health Association?

Mr. BIEMILLER. I am not sure it is a fact. I assume they would call upon people who have studied in the field at some length and draw upon their knowledge.

Senator DONNELL. You have very largely formed your judgment, have you not, on the subject of compulsory health insurance, from reading and conversing with Dr. Falk and to a limited extent with Dr. Reed?

Mr. BIEMILLER. That is not correct. I have also read the Journal of the American Medical Association; I have read the publications of the national physicians committee; I have read the publications of the bureau of medical economics of the American Medical Association; I have discussed this subject with Dr. Fishbein at great lengths. I have discussed it with George Crownhart and now his brother, Charles, who is the secretary of the society. I have had the somewhat curious honor of appearing before a special session of delegates of the Wisconsin State Medical Society to discuss the problem with them. I have not limited my reading or my personal discussion to proponents of this legislation.

Senator DONNELL. That doesn't answer my question. I said that you have formed your opinion—or in substance, I said—largely from study of the views of Dr. Falk and Dr. Reed in this regard.

Mr. BIEMILLER. I made no statement to that effect.

Senator DONNELL. You mentioned that you had talked with Dr. Fishbein and had read the Journals of the American Medical Association. You certainly didn't get anything from them that advocated compulsory health insurance in recent years, did you?

Mr. BIEMILLER. No; but——

Senator DONNELL. Did you?

Mr. BIEMILLER. May I answer the question? Many times in intellectual process one picks up a point of view in favor of some idea by reading the articles against it.

Senator DONNELL. That wasn't the question I asked you. You asked if you might answer the question. I asked you whether you found anything in any of those publications advocating compulsory health insurance?

Mr. BIEMILLER. I quoted one publication of the American Association today. That comes directly from the American Medical Association. I also recall that the minority report of the committee on the cost of medical care recommended compulsory insurance in 1932.

Senator DONNELL. Well, now, we will come to that a little bit later, as to the 1932 action. Mr. Biemiller, you know as a matter of fact, notwithstanding you have quoted here from the American Medical Association, that the house of delegates of the American Medical Association has distinctly, positively put itself on record as against compulsory health insurance; you know that?

Mr. BIEMILLER. Yes.

Senator DONNELL. And you know that instead of the opinion of the American Medical Association today being in favor of it that it is almost universally opposed to it; you know that to be true, don't you?

Mr. BIEMILLER. Yes; that is correct.

Senator DONNELL. And you know, as you have testified, that it is composed of possibly 80 to 90 percent of the practicing physicians of the United States; is that correct?

Mr. BIEMILLER. Yes.

Senator DONNELL. What is the action in 1932 to which you refer?

Mr. BIEMILLER. The minority report of the committee on the cost of medical care. The majority report was in favor of experimentation in voluntary plans and group practice.

Senator DONNELL. That was in 1932?

Mr. BIEMILLER. Yes.

Senator DONNELL. That is all.

Senator MURRAY. Mr. Biemiller, isn't it a fact that more than 90 percent of the members of the stock exchanges of the country and the security dealers were opposed to the measure designed to regulate the stock exchange?

Mr. BIEMILLER. That is my recollection. There was quite a debate at that time.

Senator MURRAY. Even after it was put into effect and in operation they came down here and tried to have it amended and changed?

Mr. BIEMILLER. Correct.

Senator **Murray**. They fought it to the very end. That is true of every reform or improvement that has been made in the history of the United States. The group entrenched by that ground, that has a very special interest, wants to reserve and monopolize. That is true in practically every plan our system in this country?

Mr. **Biemiller**. I think that is quite true.

Senator **Murray**. You stated that generally the doctors of this country have done a good job in medical care and medical service in this country. That is true, of course. No one has disputed that insofar as I know. But the members of the medical profession alone are not responsible for the excellent health conditions of the country. Isn't it due largely to the good sanitary regulations that we have in this country, to the good working conditions that we are trying to develop, the high scale of living, good water and various other things that, as you pointed out a little while ago, the fact that men working in laboratories on salaries have brought many of the wonderful cures and improvement in medical science in the country so that the medical profession—the doctor alone cannot claim credit for everything in this country regarding health conditions?

Mr. **Biemiller**. I concur heartedly with the views you have expressed, Senator.

Senator **Murray**. That is all. Thank you very much.

Senator **Donnell**. Mr. Russell Smith.

Senator **Murray**. Before you proceed to the next witness, I am sorry but I will be called away in just a few minutes. I have some letters that I would like included in the record and I will read a statement into the record:

Mr. Chairman, almost all of the testimony favoring S. 545 in principle has come from representatives of one small group of the population; a group which of right has a real interest in the matters before us but a group whose leaders have a vested interest in maintaining the economic status quo in medicine. I have here statements and facts bearing directly on their testimony. Since these represent the views of many more citizens who have an equally valid interest in their own medical care and a far greater right to decide on the methods whereby that care should be paid for, I should like them introduced into the record at this point. They are as follows:

1. Regarding testimony given by the California Medical Association and the California Physicians Service, I have here a detailed analysis of the failure of voluntary plans to meet the needs of the people in that State where they have been more thoroughly tested than in almost any other part of the Nation. This statement from the California CIO, along with that from California's American Federation of Labor, both of which have many members in California Physicians Service, is deserving of close study.

2. Regarding testimony from State medical societies that the people do not want comprehensive care under a national insurance plan, I have here statements from American Federation of Labor unions in Massachusetts, Ohio, Wisconsin, and New York showing that they, the people, do want national health insurance; statements which also show the repugnance our people feel to any measure to solve their problems through charity.

3. Regarding the testimony that the Taft bill could provide care much as the Veterans' Administration now does and that no Federal standards or controls are necessary, I have excerpts from the address given the American Medical Association by General Hawley, Medical Director of the Veterans' Administration, just a few weeks ago (June 8). They certainly lead one to wonder just how S. 545 would work out.

4. In relation to Father Schwitalla's testimony for the Catholic Hospital Association, two editorials—one from the Catholic magazine America and the other from the Catholic magazine The Commonweal—are very pertinent.

5. Medical Society voluntary plans have indicated a willingness to accept grants of charity money from the Federal Government but have insisted on monopoly control of plans by doctors and on giving only limited service. In this connection a letter from the Group Health Association of St. Paul, Minn., which laymen manage, which finds no great problem in giving comprehensive care and whose members resent any dependence on charity is worth study.

6. Since many medical society representatives have attempted to minimize the need for Federal action or have even insisted that need exists in only a few States, it seems highly desirable that some fact sheets on health insurance which briefly and pointedly set forth our needs be entered into the record at this point.

7. An unsolicited letter from a country doctor, graduate of two class A medical schools and in active practice for over 30 years—a doctor who feels so strongly that national health insurance is needed by the people that he is willing to defy the pressures of organized medicine and have his opinion published.

8. Finally, Mr. Chairman, a letter endorsing S. 545. A letter sent me by the Wayne County Medical Society in Michigan. The society favors S. 545 because it puts a doctor in control of the economics of medicine. It wants S. 545 changed, however, because it does not agree that it should be the policy of the United States to make health services available to every individual regardless of race or economic status. The society also opposes Senator Taft's S. 140, presumably because it does not guarantee that doctors will control the peoples' health services.

(The papers referred to by Senator Murray follows:)

CALIFORNIA CIO COUNCIL, RESEARCH DEPARTMENT,
San Francisco 2, June 4, 1947.

The Honorable JAMES MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: It is my understanding that the Senate Committee on Education and Labor is conducting hearings this week on Senate bill 545, the so-called Taft health bill.

I regret that these hearings have received little or no publicity and that a greater effort has not been made to hear witnesses representing the consumer's point of view. I am taking this means to State the position of the California CIO in regard to health insurance and hope that you may find the opportunity to insert our statement in the record.

As you know, we have had in California a long-sustained interest in health insurance and have also had the best opportunity to study the operation of a doctor's voluntary plan. At the request of Governor Warren, a health insurance bill (A. B. 1500) was introduced in the current session of our State legislature. Although the bill was considerably more limited in its provisions than previous bills sponsored by the Governor and by the CIO, A. B. 1500 has been effectively killed in committee.

The California Medical Association is currently pushing A. B. 950. The accompanying statement, which our CIO State executives sent to all of the members of our legislature, defines both the major intent of that bill and our position in opposing it.

Sincerely yours,

Paul G. Pinsky, *Research Director.*

STATEMENT OF CALIFORNIA CIO COUNCIL

The position of the California CIO on the subject of health insurance has been stated on more than one occasion in hearings both in our own State and in the 1946 hearings on the Wagner-Murray-Dingell bill. It is our opinion that only a bona fide system of national health insurance can meet the ever increasing medical and hospital needs of our people. We do not feel that a bill which provides a system of medical charity will meet this need. What the American people want and are entitled to is not charity but a system which will permit them to pay for medical care through the application of the insurance principle of spread-the-risk.

It is our opinion that the Taft bill (Senate bill 545) is a very sorry substitute for the comprehensive health-insurance system embodied in such a bill as Senate bill 1606 (79th Cong.), on which such extensive hearings were held last year. So-called voluntary plans, whcih the Taft bill proposes to aid, cannot hope to sove the problem.

We wish to reiterate at this time our reasons for this belief. These reasons are based primarily on the failure of the California Physicians' Service to give the people of California medical care which they require at a price they can pay.

(1) *CPS costs too much for the service given.*—Administrative and acquisition costs are very high and are not subject to control by the membership or any public body. The tremendous turn-over in voluntary membership destroys the actuarial integrity of the plan. The cost of selling the plan is tremendous. These two factors negate the advantage of the insurance principle of spreading the risk. According to CPS figures, in the months of October and November a total of 27,489 new members were acquired. The net gain in membership, however, was only 2,349.

2) *The coverage is too limited.*—CPS offers only surgical and hospital coverage to the majority of members. Medical care is not offered to families. The day-to-day medical and dental expenses of the average family are not met. Many members of CPS report annual medical expenses of hundreds of dollars, despite their CPS coverage. Preventive medicine has no part in the CPS plan.

(3) *The quality of care is poor.*—CPS physicans tend to treat CPS patients with less care than private ones. CPS is totally unable to control professional standards and practices of its physicians. In the CPS housing-projects program, completely controlled by the doctors, the average quality of care was so poor as to be scandalous. The large turn-over in membership is largely due to dissatisfaction with the service.

(4) *CPS cannot control overcharges by member physicians.*—These doctors are not satisfied with CPS fees and attempt to collect additional fees from the patient. Hundreds of complaints on this score have reached us from members of CPS.

(5) *CPS does not encourage the growth of group practice.*—The benefits of pooling skills, reducing costs, etc., which make group practice desirable, are lost to CPS members.

(6) *CPS does not seek bona fide consumer representation on its controlling board.*—The plan is completely dominated by the physicians. Members have nothing to say about dues, medical coverage, or administration. CPS seeks to perform a vital public function, while controlled by a very small minority, the physicians. Unlike a Government body, CPS has no responsibility to the people and cannot be controlled by them.

(7) *CPS has not shown good faith in an honest attempt to devise means to make medical care available to all.*—It is openly admitted by the California Medical Association that CPS was created and is maintained in an attempt to prevent the enactment of health-insurance legislation. This very attempt is proof that the physicians are aware of the need for health insurance and the desire of the people to have it.

(8) *CPS failed utterly to prove its soundness in the largest mass attempt to provide care on a prepaid basis.*—In the housing-project program CPS demonstrated that voluntary enrollments are doomed to failure. CPS and the California Medical Association officially demanded of the Government that member-

ship of public-housing tenants in CPS be made compulsory. Their contention was that only thus would the plan succeed.

(9) *CPS has continued to increase in cost while decreasing the services offered.*—Many of the faults listed above are inherent in all voluntary plans, although they are most glaring in plans sponsored and controlled by medical societies.

CALIFORNIA CIO COUNCIL,
San Francisco, Calif., June 2, 1947.

DEAR SIR: I am taking this means to express the all-out opposition of the CIO to assembly bill 950. This vicious bill is an attempt by the California Medical Association to fasten on the workers of this State by force the so-called "voluntary" plan of the California Physicians' Service. Every citizen who knows the medical needs of our people cannot but be shocked and angered by the sheer effrontery of this attempt.

A. B. 950 would permit an employer to enroll his employees under an "approved voluntary plan" without consultation with his employees and without regard to their desires, choice, or ability to pay. The employer is empowered to deduct from the wages of the employees the amounts due for payment of the plan. The employee must notify his employer in writing if he does not desire to be covered and, once covered, he must stay in the plan for the full term of the contract year. The only provision for notifying the employee of the action contemplated by his employer is one that provides that the employer post a notice that the contract has already been entered into. This bill, in effect, gives to an employer the right to impose a tax on the worker for the benefit of a private medical plan which is not controlled by, nor answerable to, the general public.

The introduction of this bill is the final proof of the hypocrisy of the medical politicians of this State and of their cynical disregard for the needs and desires of our people. Repeated polls of opinion in this State, including one made by the California Medical Association itself, prove conclusively that a majority of our people favor a State health-insurance system. Investigations over a period of 20 years by legislative and other bodies have clearly demonstrated the need for more medical care at a cost that the people can afford to pay. Each such investigation has demonstrated clearly the inability of voluntary plans to meet this need. The California physicians' service plan at present costs a worker with a family $7.90 per month. The rates for this plan have increased by 25 percent in the past 6 months, while the benefits have been decreased by the inclusion of waiting periods and numerous other restrictions. This inefficient, expensive plan does not meet more than 35 to 40 percent of the medical needs of workers and their families. The sharp reduction in the living standards of workers, as a result of skyrocketing prices, makes even more acute the desperate need for a soundly conceived, State-wide health-insurance system.

Yet in the face of this desperate need, the answer of the irresponsible leaders of the medical profession is an attempt to force an inadequate and far too costly plan like California Physicians' Service on the people. The shabby trick of compulsion embodied in A. B. 950, is a clear measure of the failure of California Physicians' Service to sell itself by voluntary means. The purpose of the bill is also to prevent the tremendous turn-over in membership which California Physicians' Service has always suffered. This huge turn-over is the natural consequence of the inability of the plan to provide the medical care needed by the worker at a price he can pay. Under the provisions of the bill, such a worker would be forced to remain in the plan even though completely unsatisfied with the amount and quality of service rendered to him under its provisions.

I call to your attention the fact that this involuntary servitude is being proposed by a group of physicians who have violently and unscrupulously attacked every attempt to solve the medical-care problem through legislative means on the grounds that "compulsion" was alien to the American scene.

The bill is carefully designed to increase and perpetuate the monopolistic control of the medical profession on the distribution of medical care. The provision in the bill which defines "an approved association of physicians or surgeons" clearly prohibits the development of consumer-sponsored cooperative medical-care groups or union medical-care centers, or such plans as the Permanente Foundation plan, which are clearly superior to the California Physicians' Service.

I want to reiterate as strongly as I can that organized labor in this State will not stand for this type of legislation. We have no intention of permitting a small and selfish body of men forever to block the struggle of our people for one of their most precious rights, the right to good health.

Sincerely yours,

MORRIS ZUSMAN,
President.
MERVYN RATHBORNE,
Secretary-Treasurer.

TRUMBULL COUNTY CENTRAL LABOR UNION,
Warren, Ohio, June 19, 1947.

Senator MURRAY,
Subcommittee, Labor and Public Welfare,
Washington, D. C.

DEAR SIR: At their last meeting, the Trumbull County Central Labor Union, affiliated with the American Federation of Labor, went on record as giving their full support to S. 1320, the National Health Insurance and Public Health Act, which is endorsed by many liberal organizations.

The delegates also voiced their opposition to S. 545, which is based on the charity principle and would require each person to undergo a means test by a State agency in order to be eligible for any of its benefits.

Yours very truly,

JACK WHITNEY, *Secretary.*

CHIPPEWA FALLS TRADES AND LABOR COUNCIL,
Chippewa Falls, Wis., May 26, 1947.

Senator JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

HONORABLE MR. MURRAY: We respectfully urge you to vote against the Taft-Smith bill, Donnell bill S. 545.

We feel this bill will not do justice to our American people in that it provides for a relief basis rather than an earned-right basis in securing health insurance.

We are also opposed to allowing a professional group to control a national medical care council, which tend to create a monopoly in medical care.

Very respectfully yours,

(Miss) ROSA HOLMES,
Recording Secretary.

LOWELL CENTRAL LABOR UNION,
Lowell, Mass., June 11, 1947.

Senator MURRAY,
Member, Subcommittee of the Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR: This organization at a recent meeting, went on record as endorsing Senate bill S. 1320 entitled "National Health Insurance and Public Health Act."

This bill calls for a comprehensive national health program through a Nationwide system of prepaid personal health-service benefits and through Federal grants to States for expanded health services. All the essential principles of national health insurance are maintained, and we feel it is the bill that will benefit the greatest number of those in need of its provisions.

On the other hand we are opposed to Senate bill S. 545 as this latter measure is based on the charity principle and would require each person to undergo a means test by a State agency in order to be eligible for any of its benefits.

Hoping you will go on record as supporting Senate bill S. 1320 and opposing Senate bill S. 545, I remain

Sincerely yours,

SIDNEY E. LEBOW, *Secretary.*

BINGHAMTON CENTRAL LABOR UNION,
Binghamton, N. Y., June 12, 1947.

Senator MURRAY,
House of Representatives, Washington, D. C.

DEAR SIR: Please be advised that we are in unanimous favor of the National Health Insurance and Public Health Act No. 1320.

We therefore urge you to consider and vote for this much-needed legislation for the benefit of the common people. We are, however, opposed to the Senate bill S. 545.

Your kind attention will be appreciated on these two pending bills and we trust that you give them your support as indicated.

Very truly yours,

EARL TUTTLE, *Secretary.*
By M. E. S.

EXCERPT FROM ADDRESS BY GEN. PAUL HAWLEY, MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, DELIVERED JUNE 8, 1947, BEFORE THE STATE MEDICAL ASSOCIATION PRESIDENTS AT THE AMERICAN MEDICAL ASSOCIATION CONVENTION, ATLANTIC CITY, N. J.

* * * We approached the problem of negotiating fee schedules with these premises to be observed: First, it was essential that the physician receive an adequate fee for his services, not only to assure his willing participation in the program but also to permit the veteran to walk into the physician's office with his head up—as a private patient rather than as a charity case. We expected the veteran to be given the best in medical care, and we were willing to pay for the average best.

Second, as a public servant I had the responsibility of protecting the American taxpayer against an overcharge. Third, although it is my legal responsibility to prevent fraud and racketeering in this program, I realized that I could never hope to have the great number of personnel necessary to check against fraud, and I was forced to ask organized medicine to undertake this duty for me.

Negotiations of fee schedules (with State medical societies) in the first three States to accept the program was remarkably simple. There were individual variations—occasionally of some size—in the fees for certain items on the schedules; but these balanced out very well, for the State which was high on one item was low on another; and we did not want to haggle so long as the average of the schedule was reasonable. I am sure that the gentlemen here present, who participated in these first negotiations, will agree with me that we had no difficulty at all in reaching a mutually satisfactory agreement.

But then our troubles began. Successive States (State medical societies) studied the fee schedules to which we had already agreed; and it was only too apparent that, in submitting their own proposals, they had selected the highest fee for each item on the schedules that had been previously approved. The result was, of course, that the average of these later proposals was much higher than the average of those agreed upon previously. They defended their position vigorously and it was evident to us that they were out for all that the traffic would bear. I cannot say that I was annoyed by such tactics; but, as a physician who still considered medicine to be an unselfish profession rather than a low trade, I must admit that I was hurt and disappointed.

These fee schedules have been attacked by influential Members of Congress on the ground that, in the vast majority of the more or less rural areas, the fees are higher than those previously charged private patients; and that our generous fee schedules have operated to raise the fees charged nonveterans. Our own investigations have proved the truth of this charge in too many instances. In one area, in addition, our fee schedule is being used as a club to force a substantial increase in the fees paid under the Workmen's Compensation Act.

Now, I ask you fairly and directly, how would you feel if you had agreed to a fee schedule which was represented to you as being the customary charges for these services in an area, and afterward you find that you have been used merely as a tool to force a rise in fees that could not have been accomplished otherwise? I can assure you that it was a bit of a blow to find that I had been taken for a buggy ride by people whom I approached in the most trusting of attitudes. The situation is that I am being severely criticized in Congress.

I hope that the people who made me vulnerable to this criticism are not now laughing at me for being taken in.

I want to say emphatically that the majority of our agreements with State associations or other agencies are working well, so far as we are concerned. If they are not working well for the associations' point of view, I want to know it. But there are some areas in which there is a noticeable want of cooperation. I am sure that some of the fault lies in our side, and I shall try very hard to mend our ways. But I cannot, and shall not, assume all of the responsibility for this want of cooperation.

For example, under threat of refusal to renew our agreement, certain areas have demanded that we cease all out-patient treatment in our clinics and refer every such patient to a fee-basis practitioner. These physicians must have forgotten that I have also a responsibility to the American taxpayer, and that, while I desire that the bulk of the effort of our out-patient clinics be directed toward medical examinations for pension claims, I cannot, in conscience, permit our people to sit around and twiddle their thumbs if there be no cases to examine at the moment. Furthermore, a large proportion of out-patient cases require only one simple treatment, and it is more trouble to the fee-basis practitioner as well as the Veterans' Administration, to authorize only one treatment than it is to give it at once at our clinic. I have found that the majority of private practitioners do not want to bother with only one treatment.

Then there is the area in which the representatives of the physicians demanded that I give the veteran a free choice of physicians in the conduct of examinations for pension claims. Now, wouldn't that be something? There are, I regret to say, enough rascals even in organized medicine, that a fraudulent claimant would have little difficulty in perfecting his claim. And, after all, for whom is a medical examination for a pension claim, or for life insurance made? It is made entirely for the benefit of the individual as is the case of an out-patient treatment. Has not the Government, or the life insurance company, some interest in the examination?

It may be that I regard these infrequent occurrences too seriously. Certainly the great majority of the medical profession of this country has been more than fair with the Veterans' Administration. Many of the leaders of the profession have given unstintingly of their time—at ridiculously low pay—in assisting us in our task. But the danger lies in the fact that 10 percent of grasping and selfish people in an organiaztion, or in a profession, can give it a bad reputation despite the fact that 90 percent are honorable, upright, and unselfish gentlemen.

But let us consider, for a moment, just how badly the Veterans' Administration is treating the medical profession of the country. With agreements signed with only 38 of our 48 States, we are now paying private practitioners more than $2,500,000 a month in fees—some $32,000,000 per year. There are approximately 150,000 physicians in active practice in the United States. This is an average payment of about $213 per physician per year. There are less than 2,000,000 veterans with established service-connected disabilities, and these represent less than one-seventieth of our population. Because of the age of the great majority of these pensioners, and because they are entitled to treatment at Government expense only for their service-connected disabilities and not for any other ailment, the out-patient treatment to which they are entitled represents very much less than one-seventieth of the medical practice of the country; but, in order to make the worst possible case, let us assume that the out-patient treatment of their service-connected disabilities does represent one-seventieth of the total medical practice in the United States. If the $213 per annum that we pay the average physician in the United States each year, represents one-seventieth of his practice, the average physician in the United States today collecting $15,000 a year, and you know this is not true. So the cold fact is that, on the average for the entire country, the business being given to private practitioners by the Veterans' Administration is considerably more than the average they are getting from the rest of their patients. I realize that this business is not distributed equally, but no one since Huey Long has had any plan for sharing the wealth; and the profession, as a profession, can speak only for the entire profession, and not for any favored individual or group.

I don't think we are doing too badly by the private practitioner; and, because of these figures, I take a rather jaundiced view of efforts to jack up the ante * * *.

[From America, May 31, 1947]

COMPETING HEALTH BILLS

The President's message on a Federal health program added fuel to the fires of controversy as to just how such a program should be formulated. On the one side are those who think with Senator Taft that the function of the Federal Government is to supply grants-in-aid to the States for extended public assistance to the indigent. On the other are those who favor a comprehensive scheme which would provide minimum health benefits for all as a right acquired by participation in an insurance program. Neither side denies the need for expanded research in medicine. Both agree on the desirability of better public-health services and are willing to assist the States in developing them. The controversial issue is that of health insurance. Mr. Taft and his associates, who in the Seventy-ninth Congress backed a bill similar to S. 545 sponsored in this Congress, start with the supposition that only the lowest income groups need help in meeting medical costs and that this is best provided by direct public assistance. Those favoring general insurance coverage, among whom are Senators Wagner and Murray, take the position that since well over 50 and often 75 or 80 percent of our people cannot meet medical costs for major illnesses without insurance, it is time we developed a comprehensive insurance program. They point out that, despite all efforts to date, over-all insurance on a purely voluntary basis has reached but a small minority, often the best able to afford it. Therefore, they say, let us extend social security to include medical needs. The net outcome of the controversy at this stage of the present session of Congress will probably be that nothing new will be done for a health program. Senator Taft, while promising early hearings in answer to President Truman's plea, sees no room for health legislation on the legislative schedule this session. The Taft bill, already granted hearings, is attacked by opponents on the grounds that it substitutes public charity for social justice.

[From the Commonweal, May 23, 1947]

NATIONAL HEALTH INSURANCE

National health insurance will come nearer realization when Senator Wagner, in company with Senators Murray, Pepper, Chavez, Taylor, McGrath, and Representative Dingell, introduces for consideration by members of the Eightieth Congress a bill entitled "The National Health Insurance Act." The bill is an improved version of a national health-insurance bill that was drawn up by several of the same men during the last session of Congress. Key objections hurled at their bill during last year's prelegislative talks have been met, and this time Senator Wagner and his colleagues mean business. The bill may not reach the voting stage in this session, but its presentation is a sign that the problem has not been forgotten and that, sooner or later, Congress will be compelled to come to grips with it.

By now the rudimentary part of the struggle for a national health bill should be over. Senator Wagner and his fellow sponsors should not be forced to exhaust themselves on a new discussion of the basic arguments in favor of such a bill. It should be generally recognized that a high level of national health is just as important—though less dramatic—as the question of American international stewardship and the Truman doctrine. It should be apparent that the medical splendors which exist in America are not available for all of the people, or even for most of the people. And it should be remembered that only 3 percent of the citizens of this country reecive medical and hospital services by way of privately conducted health-insurance schemes. The question should no longer be, Is a national health-insurance bill necessary and important? Rather, it should be, What kind of Federal health legislation will be most practicable and effective? The Congressmen who have introduced the National Health Insurance Act have been constructing an answer to that question for a long time now, and they believe that their answer—an extension of the principle of Social Security—is a good and comprehensive one.

The new bill provides for a broad national health program that will be sustained by means of Federal grants and regular individual payments, the latter levied and collected in a manner similar to existing social-security laws. All citizens will be eligible and all medical and dental services will be available. Doctors and hospitals may be freely selected from among those who wish to participate in the plan. No doctor will be compelled to participate. Each State will receive an annual grant which will be expended by the State through local agencies.

The social mood of the Eightieth Congress does not seem to be particularly constructive, so the National Health Insurance Act may not become a law at this session. Nevertheless, the problem attacked by the bill will not disappear, and when the Members of Congress are ready to have a go at it they will find a sound piece of legislation at hand—thanks to Senator Wagner and his coworkers.

GROUP HEALTH ASSOCIATION,
St. Paul 4, Minn., May 23, 1947.

Hon. JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: I believe that on the basis of experience in two fights on medical legislation in the State of Minnesota, it is fair to say that the people of Minnesota are opposed to the principles embodied in the Ball-Taft bill (S. 545).

This bill embodies principles sought by the doctors. It is diametrically opposed to the principles endorsed by the Minnesota State Federation of Labor, the Minnesota CIO, the central labor bodies of Minneapolis, St. Paul, and Duluth, the Minnesota Farmers Union, the Minnesota Association of Cooperatives, the railroad brotherhoods, and Group Health Association—an organization of more than 100,000 persons.

The principles we seek are embodied in enabling legislation to permit the people to organize cooperatively to provide for their health needs. This legislation (copy enclosed) was introduced in the last session of the legislature and was successfully fought by the officialdom of organized medicine, even though many of the doctors wanted it.

We believe that the motivating force behind the officialdom's opposition to our measure was the same the motivating force behind their support of the Ball-Taft bill, namely, commercial. We see no reason for supposing that it will help get medical care where it is needed, and we feel sure that the people generally will strongly resent anything so un-American as the measure's classification of a large block of self-supporting Americans as "indigent." This retrogressive principle is as alarming as it is deplorable, and we ask you to challenge it with all the power at your command.

Our experience in Minnesota has been that giving the doctors more power and more money (as the Ball-Taft bill will do) will not give the people of our State more medical care. The doctors, in 1945, through trickery, misrepresentation, and cloakroom pressure, got a medical-monopoly law giving the doctors exclusive control over prepayment-medical-care plans. In the intervening 2 years, while the people of Minnesota, suffering from inadequate facilities, were forbidden to organize their own plans, the medical profession has done nothing. To date no medical association prepayment plan is available. If it were available, it would fail to do the necessary job because the doctors' proposed program follows the familiar pattern of blocking contractual relationships between doctor and patients to provide facilities and service where they are needed.

Thus, the doctors, while asking the right to bar others from acting, have done nothing themselves. They have gone further. Manley Brist, assistant attorney general of Minnesota assigned to the State medical board of examiners, has boasted to this writer that his group is going to destroy the health cooperative at Two Harbors, where the people are carrying on without benefit of incorporation.

In opposing our bill, the doctors' officialdom used tactics similar to those used by the liquor-slot machine lobby. By rule of fear they scared the legislators from taking a position on the bill, despite the overwhelming wishes of the people of our State. They also indicated a division within their own ranks. Mr. Brist and Dr. A. W. Adson testified to what they called the ignorance, carelessness, and incompetence of rural doctors, indicating their wish to have medical services concentrated in urban centers. They did not mention the interesting possibility that this concentration might be more to the interest of the businessmen of medicine than to the doctors and patients these businessmen would exploit. Evidently the Ball-Taft measure would encourage concentration.

One danger of the Taft-Ball bill lies in its acceptance of solutions that do not solve. The officialdom of organized medicine has been preaching this approach for several years, without any particular result except that the farmers are getting more and more up in arms. The farmers are convinced of the need for the right to organize to meet their own problems. The medical officialdom who are pressing for the Taft-Ball measure are the same people who are fighting the farmers' right to organize. I submit that they do not come to you with clean hands, and that there is no evidence in their record of a true concern for the health needs of the people.

It is repugnant to all Americans to have so un-American a principle established in law as that offered by the Taft-Ball measure. I have no particular objection to the doctors going on WPA under this measure if they want to, but I object to giving them Government funds to be used in blocking a genuine solution of the problem, and giving them the right to stigmatize a large section of self-supporting fellow citizens as "indigent." The fact that they want to stigmatize some people in this way while themselves accepting charitable contributions from the Government is shocking to many of us. I feel quite sure that as the true significance of this bill becomes known among the people there will be a storm such as our political leaders have rarely seen.

Very sincerely yours,

FREDERICK S. GRAM.

GROUP HEALTH ASSOCIATION,
St. Paul, Minn., June 5, 1947.

HON. JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: Thank you for your letter of May 28 acknowledging mine of May 24 urging a vote against the Taft health bill.

I note that you propose to place my letter in the record, and I have a request to make in this connection. While it was originally intended for the record, a question of policy has been raised which makes it important to my organization that it be modified somewhat. I am, therefore, writing to ask that the modifications in the enclosed copy of the original letter be used for the record.

Very sincerely yours,

FREDERICK S. GRAM.

THE COMMUNITY HEALTH BILL

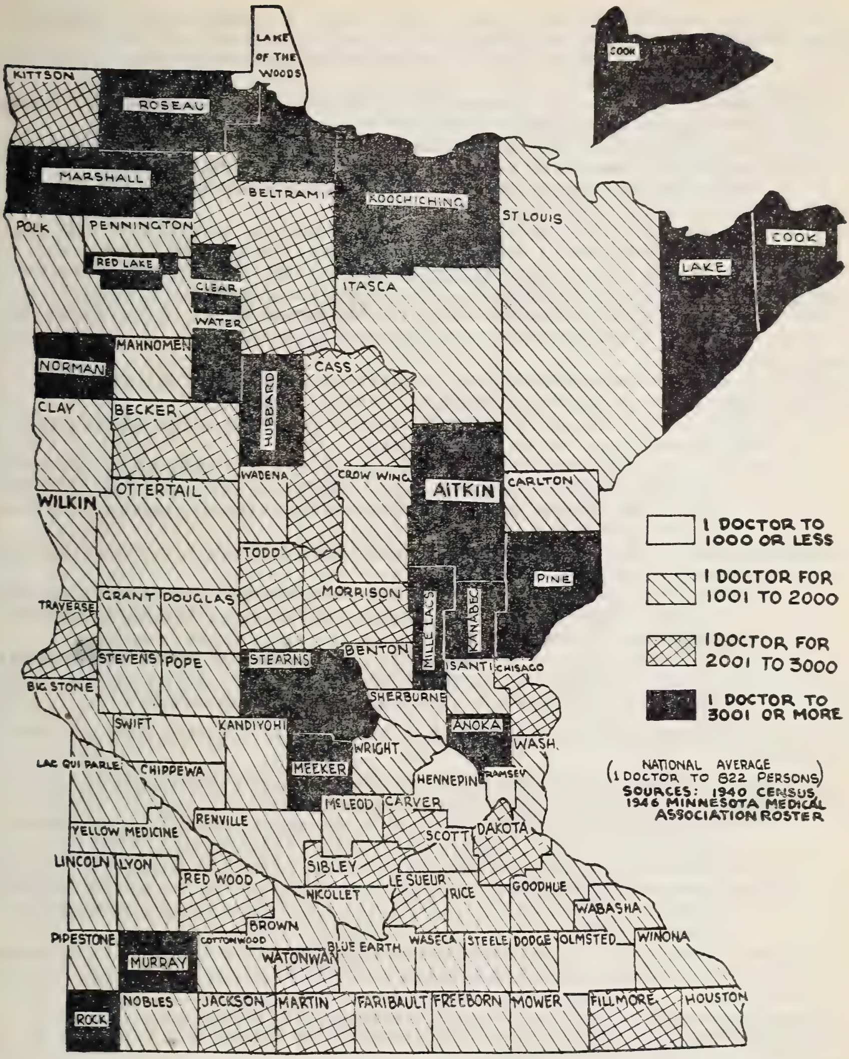
WHAT IT DOES

1. It removes the economic barrier between doctor and patient by allowing communities to organize voluntary prepayment medical-care plans.
2. It gives the communities now suffering from lack of physicians, hospitals, and medical-care facilities the legal right, now denied to them, to create the economic conditions necessary to attract needed doctors and build needed facilities.
3. It establishes by law the right of the people to plan and pay for the risks of sickness and accidents in an orderly, sensible way by budgeting in normal times for times of crisis.
4. It strengthens the principle of the patient's freedom of choice of physician, particularly in rural areas, by setting up conditions which will support a greater number of physicians in fields where the choice is now limited.

WHY IT IS NEEDED

1. The incorporation of nonprofit voluntary prepayment plans such as the proposed bill provides for is now forbidden under the attorney general's interpretation of the common law.
2. Medical care is now badly distributed because of the legal restriction preventing communities from organizing to meet their own health needs. Many areas have not enough physicians. (See map on p. 947.)
3. Our failure to meet the health needs of the people is reflected directly in their physical well-being. Selective Service records for World War II showed 43 rejections for physical reasons out of every 100 selectees in urban areas and 53 per 100 in rural areas where health facilities are most inadequate.
4. No other plan has been offered that is doing the necessary job.

THE MINNESOTA ASSOCIATION OF COOPERATIVES.


LAKE OF THE WOODS
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RED LAKE
CLEAR WATER
ITASCA
LAKE
MAHNOMEN
NORMAN
CASS
HUBBARD
CLAY
BECKER
WADENA
CROW WING
AITKIN
CARLTON
WILKIN
OTTERTAIL
TODD
PINE
MORRISON
MILLE LACS
KANABEC
TRAVERSE
GRANT
DOUGLAS
STEVENS
POPE
STEARNS
BENTON
ISANTI
CHISAGO
BIG STONE
SHERBURNE
SWIFT
KANDIYOHI
ANOKA
WASH.
WRIGHT
LAC QUI PARLE
CHIPPEWA
MEEKER
HENNEPIN
RAMSEY
McLEOD
CARVER
RENVILLE
YELLOW MEDICINE
SCOTT
DAKOTA
LINCOLN
LYON
RED WOOD
SIBLEY
LE SUEUR
NICOLLET
RICE
GOODHUE
WABASHA
BROWN
PIPESTONE
MURRAY
COTTONWOOD
BLUE EARTH
WASECA
STEELE
DODGE
OLMSTED
WINONA
WATONWAN
ROCK
NOBLES
JACKSON
MARTIN
FARIBAULT
FREEBORN
MOWER
FILLMORE
HOUSTON
☐ 1 DOCTOR TO 1000 OR LESS
▧ 1 DOCTOR FOR 1001 TO 2000
▦ 1 DOCTOR FOR 2001 TO 3000
■ 1 DOCTOR TO 3001 OR MORE

(NATIONAL AVERAGE 1 DOCTOR TO 822 PERSONS)
SOURCES: 1940 CENSUS, 1946 MINNESOTA MEDICAL ASSOCIATION ROSTER

HEALTH INSURANCE FACT SHEET

1. On an average, two persons out of every three need help to meet the cost of serious illness.[1]

2. About 97,000,000 people in the United States need help to meet the cost of serious illness.[1]

3. In the course of a year, there are approximately 22,000,000 disabling illnesses, lasting a week or longer, in the United States.[2]

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[1] Families with incomes under $3,000 need help in meeting the cost of serious illness. (Factual Data on Medical Economics, pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association.) 69 percent of the United States population lived in such families in 1945. (National Survey of Liquid Asset Holdings, Spending and Saving, Part II: Relation of Savings and Holdings to Income, July 1946. Bureau of Agricultural Economics, U. S. Department of Agriculture.)

[2] Public affairs pamphlet, Who Can Afford Health[by Beulah Amidon, 1944, p. 9.

4. At least 7,000,000 people in the United States are disabled by sickness or other disability in any 24-hour period, half of them for 6 months or more.[3]

   (a) One person out of every 20 is disabled by sickness or disability in any 24-hour period.

5. The total hidden costs of sickness and disability, wage loss to workers, and costs to business totaled in 1943 not less than $15,000,000,000.[4]

6. The estimated annual cost of sickness and accidents, in medical costs and loss of earnings due to sickness and premature death, is $8,000,000,000.[3]

7. It is estimated that only about $20,000,000 a year is being spent for research to find causes and new treatments of diseases.[5]

8. In contrast with this, the Department of Commerce reported in 1943 that approximately $275,000,000 is being spent each year for industrial research.[6]

9. In 1947, Congress appropriated $29,866,200 for the Department of Agriculture alone for research in the control and cure of plant and animal diseases.[7]

10. After about 14 years, only about 21,755,766 people, about 16 percent of the population of the United States, were covered by hospitalization plans as of July 1, 1946.[8]

11. Only about 3,500,000 Americans (2½ percent of the population) were covered by comprehensive medical-care plans in 1945.[9]

12. In 1941 there was, on the average, approximately 1 active physician for every 1,400 to 1,500 people in the United States.[10]

   (*a*) In 1944, 553 counties in the United States (18 percent of the total of 3,070 counties) had less than 1 active physician per 3,000 population (the danger line), and 81 counties (over 2½ percent) had no active doctor at all.[3]

13. More than 10 percent of the people in the United States live where there is no approved general hospital.[3]

   (*a*) Forty-one percent of the counties in the United States (approximately 1,258 counties) with an aggregate population of 15,000,000, have no approved general hospital.[3]

   (*b*) Forty-eight percent of the counties in the United States (1,473 counties) have under the standard of 4.5 beds per 1,000 population; and only 11 percent (337) of the counties meet the standard.[11]

I. How many people in the United States need help to meet the cost of serious illness?

1. Two people out of every three who live in the United States—about 97,000,000 Americans—need help to meet the cost of serious illinois.[12]

   (*a*) This statement is based on an estimate made in 1939 in a publication of the American Medical Association, that families with incomes under $3,000 need help to meet the cost of serious illness.[12]

   (*b*) However, by 1945 the cost-of-living index had increased by 29 percent over 1939; and in April 1947, the index was 50 percent higher than in 1939.[13]

   (*c*) Therefore, it is reasonable to assume that many people with incomes over $3,000 now need help to meet the cost of serious illness.

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[3] Senate Subcommittee Rept. No. 5 (Health Insurance), July 1946, p. 1.

[4] Federal Security Agency fact sheet, The Health of the Nation, June 1, 1946, p. 2.

[5] Amounts of which are as follows:

American private foundations, 1940	$4,700,000
National Cancer Institute (U. S. Government), 1946–47	1,772,000
National Institute of Health (U. S. Government), 1946–47	5,966,948
Veterans' Administration, National Research Council (approximate)	1,000,000
American Cancer Society, 1946	2,500,000
National Foundation for Infantile Paralysis, 1946	1,858,826
Medical schools and teaching hospitals (estimated)	2,500,000
Total	20,297,774

[6] Report of survey released by Department of Commerce in 1943.

[7] Budget of the United States, fiscal year ending June 30, 1948.

[8] World Almanac, 1947, p. 772. (Total Blue Cross coverage, 23,132,508; Canada, 1,376,742; United States, 21,755,766.)

[9] Senate Subcommittee Rept. No. 5 (Health Insurance), July 1946, p. 6.

[10] Senate Committee Print No. 5 (Medical Care Insurance), July 8, 1946, p. 35. Standard: 1 physician to every 1,000 people. (Same, p. 35.)

[11] Senate Committee Print No. 3 (National Health Act of 1945), March 1946, p. 52.

[12] Families with incomes under $3,000 need help to meet the cost of serious illness (Factual Data on Medical Economics, pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association), 69 percent of the United States population live in such families. (National Survey of Liquid Asset Holdings, Spending and Saving: Bureau of Agricultural Economics, U. S. Department of Agriculture, July 1946.)

[13] Bureau of Labor Statistics: 1939 yearly average, 99.4; 1945 yearly average, 128.4; April 1947 monthly average, 156.1. (1935–39=100.)

II. What is the annual loss to the United States because of sickness, disability, and premature death?

A. In terms of people, the United States lost—

1. In 1945, excluding those who died in the armed forces overseas, 1,401,719 Americans, through death. Of these—[14]
    - (*a*) 11 percent, or 162,006, were under 20 years of age.
    - (*b*) 8 percent, or 112,442, were aged from 20 to 39.
    - (*c*) 19 percent, or 274,448, were under 40 years of age.
    - (*d*) 23 percent, or 321,921, were aged from 40 to 59.

    This means that—
    - (*e*) 42 percent, or 596,369, of the Americans who died in this country in 1945 were under 60 years old.
2. About 1,000,000,000 days of disability each year from chronic illnesses.[15]
    - (*a*) There are approximately 22,000,000 disabling illnesses every year in the country as a whole.[16] 1. Each of these illnesses lasts, on the average, about 57 days.[16]
    - (*b*) Over 40 percent of the Nation's selectees were found unfit for military duty.[17] At least 17 percent of those found unfit had defects which were remediable; many more had preventable defects.[17]

B. In terms of production, the United States lost—

1. About 600,000,000 man-days annually.[18]
    - (*a*) Illness and accidents cause the average industrial worker to lose about 12 days from production each year.[18]
    - (*b*) More than 75 percent of the 25,000,000 chronic disease cases in the United States are among people in the productive years from 15 to 64; half of these people are less than 45 years old; 16 percent of them are under 25.[19]

C. In terms of money, the United States lost—

1. An estimated $8,000,000,000 annually, half in medical costs and half in loss of earnings due to sickness and premature death.[18]
    - (*a*) It is estimated that American workers lost $560,000,000 in wages, in strikes during the first 6 months of peace; at this rate, the annual wage loss would be $1,120,000,000, in contrast with the $8,000,000,000 lost through sickness and premature death.[20]
2. It is estimated that the total hidden costs of sickness and disability, wage loss to workers and costs to business, totaled in 1943 not less than $15,000,000,000.[21]

III. What do we spend on health, compared with what we spend on other things?

1. In 1942, the American people spent only about 3 percent of the total national income on medical care.[22]
    - (*a*) It has been estimated that the people of the United States will spend $5,499,963,211 in 1947 for medical care, including supplies and insurance.[23] This is less than 3½ percent of the national income in 1945 (latest figure available).[24]
2. In contrast with this, the people of the United States, to protect our lives against a possible enemy, will spend 50 percent for armed defense this year than for all types of medical service to protect ourselves against disabilities and deaths of our people.

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[14] U. S. Bureau of Vital Statistics.

[15] George St. J. Perrott, U. S. Public Health Service: The Problem of Psychosomatic Disease, article in Psychosomatic Medicine, January 1945.

[16] Public Affairs pamphlet, Who Can Afford Health? by Beulah Amidon, 1944, p. 9.

[17] Senate Subcommittee Rept. No. 5, 79th Cong., Health Insurance, July 1946, p. 1.

[18] Senate Subcommittee Rept. No. 5, 79th Cong., Health Insurance, July 1946, p. 1.

[19] George St. J. Perrott, U. S. Public Health Service: The Problem of Chronic Disease, article in Psychosomatic Medicine, January 1945.

[20] United States News, March 1, 1946.

[21] Federal Security Agency fact sheet, Health of the Nation, June 1, 1946, p. 2.

[22] Spent for medical care in 1942, $3,710,000,000 (America's Needs and Resources, published by Twentieth Century Fund, 1947); national income, 1942, $122,232,000,000 (World Almanac, 1947).

[23] The Medical Market—Forecasts for 1947 (Modern Medicine).

[24] National income, 1945, $160,952,000,000 (World Almanac, 1947, p. 395).

        (*a*) Proposed expenditures for national defense in 1947–48: Army and Air Forces, $5,240,900,000,[25] Navy, $3,469,761,000[26] or a total of $8,710,661,000 for national defense, as against $5,499,963,211 for medical care, supplies, and insurance.

3. In contrast with the estimated amount of $5,499,963,211 which the people of the United States will spend in 1947 for medical services, supplies, and insurance, the same people in 1946 spent $8,700,000,000 for alcoholic beverages. This is an average of $89 a year for liquor for each person over 18 years old.[27]
    - (*a*) 50 percent more is spent on liquor than on all health services in a year!

IV. How many doctors are there in the United States; how much do they earn?

1. In 1942 there were 180,496 registered physicians in the United States, including all types of specialists.[28]
    - (*a*) In 1943 the number of "effective physicians" was estimated at 135,932.[29]
2. Taking a standard of 1 active physician for every 1,000 patients:[30]
    - (*a*) In 1941 there was approximately 1 active physician for every 1,500 people in the United States (if doctors had been evenly divided throughout the country).[30]
    - (*b*) However, in 1944, 553 counties in the United States (18 percent of the total of 3,070 counties) had less than 1 active physician per 3,000 population (the "danger line"), and 81 counties (over 2½ percent had no active doctor.[31]
3. The national net average income of American doctors in 1941 was $5,047; but this figure was overweighted by top-bracket specialists.[32]
    - (*a*) About 25 percent had net incomes of less than $2,000.[32]
    - (*b*) About 16 percent had net incomes of less than $1,000.[32]
    - (*c*) About 12½ percent had net incomes of $10,000 or more.[32]

V. How many hospitals are there in the United States?

1. In 1945, there were 1,738,944 hospital beds in 6,511 hospitals in the United States.[33]
    - (*a*) However, approximately 15,000,000 Americans, living in 40 percent of the Nation's counties, have no recognized general hospital.[34]
    - (*b*) Taking 4.5 beds per 1,000 population as the standard for hospitals:[35]
        1. Only 11 percent of the counties of the United States meet this standard.[36]
        2. 48 percent of the counties in the United States have under this standard.[36]
        3. 41 percent of the counties in the United States have no approved general hospital.[36]
    - (*c*) 16,257,402 patients were admitted to hospitals in 1945, or an average of about 1 out of every 8 people in the United States.[33]

2. Of 15,800,000 patients admitted to registered hospitals in 1944[37] 95.1 percent, or 15,000,000, were admitted to general hospitals having 54 percent of total beds; 2.9 percent, or 500,000, were admitted to special hospitals having 3 percent of total beds;[38] 1.4 percent, or 200,000, were admitted to nervous and mental hos-

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[25] Amount recommended by Appropriations Committee as of June 3, 1947 (New York Times).

[26] Amount passed by House as of June 3, 1947 (New York Times).

[27] Department of Commerce, April 30, 1947 (Associated Press dispatch, Washington, New York Times).

[28] AMA Directory, 1942, p. 8 (latest issue).

[29] AMA Journal, vol. 121, p. 1163 (1943): Total registered physicians, 1943: 179,039; difference represents those not practicing because of advanced age, physical disabilities, and other reasons.

[30] Senate Committee Print No. 5, 79th Cong., July 8, 1946, p. 35.

[31] Senate Subcommittee Rept. No. 5, 79th Cong., July 1946, p. 1.

[32] Senate Committee Print No. 4, 79th Cong., March 1946, p. 17 (figures from Survey of Current Business, vol. 23, No. 10, October 1943).

[33] World Almanac, 1947, p. 773.

[34] Senate Subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

[35] Public Health Bull. No. 292, Health Service Areas. Issued by U. S. Public Health Service, 1945, p. 5. (Estimate does not include beds for patients suffering from tuberculosis or mental disorders.)

[36] Senate Committee Print No. 3, 79th Cong. (National Health Act of 1945, and hospital survey and construction bill), March 1946, p. 52.

[37] Senate Committee Print No. 4, 79th Cong. (National Health Act of 1945), March 1946, p. 20.

[38] Includes maternity, industrial, eye-ear-nose-and-throat, children's orthopedic, isolation, convalescent and rest, etc.

pitals having 38 percent of total beds; 0.6 percent, or 100,000, were admitted to tuberculosis hospitals having 5 percent of total beds.

VI. How much do we spend for research for new treatments and cures to save our people from death or disability?

1. It is estimated that only about $20,000,000 a year is being spent for research to find cures and new treatments of diseases.[39]
   - (*a*) In contrast with this, the Department of Commerce reported in 1943 that approximately $275,000,000 is being spent each year for industrial research.[40]
   - (*b*) In 1947, Congress appropriated $29,866,200 for the Department of Agriculture alone, for research in the control and cure of plant and animal diseases.[41]
   - (*c*) In contrast with the 1947 total appropriation of $104,088,516 for the United States Public Health Service, Congress made a total appropriation of $744,489,692 in 1947 for the Department of Agriculture.[41]

VII. How much more would a national-health-insurance program cost the people of the United States than they spend under the present system?

1. It is estimated that about $5,499,963,211 will be spent by the people of the United States for medical care in 1947, including medical services, medicines, and supplies, and health and accident insurance.[42]

2. In a study made in 1941, it was found that money spent by sample family groups for medical care was distributed as follows:[43]

	Health and accident insurance	Medicines and supplies	Medical services	Total
Groups with incomes between $500 and $1,000	$2.13	$9.16	$15.14	$25.12
Groups with incomes between $1,000 and $1,500	4.48	16.28	37.15	57.91
Groups with incomes between $2,500 and $3,000	7.83	18.06	63.99	89.88
Groups with incomes between $3,000 and $5,000	11.39	33.99	107.69	153.07

3. Family expenditures for medical care under the proposed national health insurance bill,[44] for people in comparable income groups, would be as follows:[45]

Insurance premiums at 3 percent

Annual earnings:	*Insurance premiums at 3 percent*
$750	$22.50
$1,250	37.50
$2,500	75.00
$3,600 and over	108.00

4. The above two tables show that the total average family expenditures for medical care under the national health insurance bill[44] would be lower than they were in 1941 under the present system.

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[39] The amounts are as follows:

American private foundations, 1940 (latest estimate)	$4,700,000
National Cancer Institute (U. S. Government), 1946–47	1,772,000
National Institute of Health (U. S. Government), 1946–47	5,966,948
Veterans' Administration, National Research Council (approximate)	1,000,000
American Cancer Society, 1946	2,500,000
National Foundation for Infantile Paralysis, 1946	1,858,826
Medical schools and teaching hospitals (estimated)	2,500,000
Total	20,297,774

[40] Report of survey released by Department of Commerce in 1943.

[41] Budget of the United States, fiscal year ending June 30, 1948.

[42] The Medical Market—Forecasts for 1937 (Modern Medicine).

[43] Study of Family Spending and Saving in Wartime, 1941 and the first quarter of 1942. August 1942. U. S. Bureau of Labor Statistics and Bureau of Home Economics.

[44] Introduced in May 1947 by Senators Wagner, Murray, Chavez, Pepper, Taylor, and McGrath.

[45] Senate Committee Print No. 5, 79th Cong., July 8, 1946, p. 158.

VINTON, IOWA, *June 3, 1947.*

Senator JAMES MURRAY,
Washington, D. C.

DEAR SIR: I have practiced medicine and surgery since 1909, graduate of two class A medical colleges, did an internship in Flower Hospital, New York City, and had a good active general practice in which I have done considerable surgery, and I feel that the general public will be much better off with medicine and surgery as controlled by some law that makes the treatment of diseases so that all classes of people can receive treatment.

I have practiced right here in central Iowa where all can receive treatment and not in the poorer parts of the country, but I know that the public are exploited. I firmly believe that one-half the surgery that is being done is not necessary, one-fourth is a distinct damage to the patient. The young men coming out of their internships are 75 percent wanting surgery because of the income and not for the good of the patients. This is not right. The real medical man who is concerned with the welfare of his people also believes that health insurance or the medical practice as handled by the Government will be a real benefit to the people and they will not be exploited. I am sorry to see the way the medical profession is looking at the care of their patients. It is a means to make money and not a service.

Don't know just why I write this except that I am disgusted with things I am seeing done every day, under guise of care of the sick.

Yours truly,

CHAS. A. MANAHAN, M. D.

WAYNE COUNTY MEDICAL SOCIETY,
Detroit 1, Mich., April 21, 1947.

Senator JAMES E. MURRAY,
Senate Building, Washington, D. C.

DEAR SENATOR MURRAY: The council of the Wayne County Medical Society, at its meeting of April 11, 1947, went on record as being opposed to S. 140—the Fulbright-Taft bill—because it would place health activities under a lay secretary. The Wayne County Medical Society believes that the health of the Nation is too important to be combined with welfare and education and is in favor of an independent health agency headed by a doctor of medicine as is provided for in S. 545—the Taft-Smith-Donnell health bill. The council approved S. 545, subject to various corrections and deletions as outlined on the attached page.

Your consideration of the above recommendation, which expresses the opinion of the medical profession in Wayne County, will be appreciated.

Sincerely yours,

WARREN W. BABCOCK, M. D.,
Secretary.

CORRECTIONS AND DELETIONS TO S. 545 AS RECOMMENDED BY THE WAYNE COUNTY MEDICAL SOCIETY

Page 2, lines 14, 15, 16: Delete "to every individual regardless of race or economic status".

Page 4, line 25: Delete "and all other health activities".

Page 5, lines 17, 18, 19, 20: Delete "such related matters as shall aid the States and the people of the United States in the maintenance of adequate and efficient health facilities and otherwise promote the national health".

Pages 9, 10, 11: That the Office of Maternal and Child Health be not made a special section but placed under the Office of Medical and Hospital Care Service.

Pages 12–13, lines 22, 23, 24: lines 1–17: That section 203 be deleted.

Page 14, lines 7 and 8: Delete words "to remain available until expended".

Page 16, lines 2 and 4: Delete words "as he may determine" and substitute the word "annually" for the phrase "time to time".

Page 16, lines 13, 14, 15: Amend to read "Any funds appropriated to a State under this section and not expended should be used in the following year".

Senator DONNELL. What is the name of that doctor you referred to?

Senator MURRAY. Charles A. Manahan.

Senator DONNELL. Before you go, I have in my possession a copy of a letter which I take it is from Senator Smith and which he wanted read into the record upon reconvening of this subcommittee on July 2, 1947. I imagine Senator Smith has the original of this letter. Do you desire to set it in the record?

Senator MURRAY. I spoke to him about it and he suggested another method of accomplishing what we sought in that and I agreed with him.

Senator DONNELL. May I ask you, did you write that letter?

Senator MURRAY. It was written through me. I didn't write it myself.

Senator DONNELL. Do you mind stating who wrote it or prepared it?

Senator MURRAY. It was prepared by my son Charles.

Senator DONNELL. It wasn't Mr. Green?

Senator MURRAY. Not that I know of. It was prepared by Charles. I told him to get it ready and he got it for me.

Senator DONNELL. You now want to withdraw it?

Senator MURRAY. You can put it in the record if you so desire.

Senator DONNELL. The chairman of this subcommittee, Senator Smith, handed it to me.

Senator MURRAY. I am perfectly willing to have it put in the record.

Senator DONNELL. Which do you want?

Senator MURRAY. We agreed with Senator Smith that we should handle it another way. I will change the arrangement as Mr. Smith is perfectly satisfied.

Senator DONNELL. I haven't asked you to change anything. I just asked you whether you wanted it in this record.

Senator MURRAY. I will put it in the record.

Senator DONNELL. I do not have your signature but I assume this is a true letter and I will add your signature "James E. Murray."

(The letter referred to follows:)

JUNE 27, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, Committee on Labor and Public Welfare, Senate Office Building, Washington, D. C.

MY DEAR SENATOR: I understand that on June 24, in my absence, a Dr. Maurice H. Friedman submitted to the subcommittee a statement which—if accepted at face value—raises serious doubts as to the validity of factual reports prepared by the United States Public Health Service, the Social Security Board, and other agencies of the Government and questions the honesty or intelligence of their interpretations of other facts.

I understand, too, that a proposal was made that the Friedman testimony be published by the committee as a separate document for widespread distribution to doctors and others throughout the country.

I regard as serious any matter which questions the integrity of public servants and casts doubt on the reliability of official reports of the Government of the United States. I have asked Mr. Watson Miller, Federal Security Administrator of the Federal Security Agency, to prepare a reply to Dr. Friedman's statement. I hereby request that you instruct the clerk of the committee to withhold the printing of the Friedman testimony until the Federal Security Agency's analysis of that testimony is received and that you further instruct Mr. Rodgers to see to it that both the statement and the reply thereto are published in the same volume.

I am sure you will agree that this course is incumbent upon us as a matter of simple fairness to those public servants whose integrity or intelligence have been called into question and as a matter affecting the honor and prestige of the executive branch of our Government.

I ask that this letter be read into the record upon the reconvening of the subcommittee on July 2, 1947.

Sincerely yours,

James E. Murray.

Senator Donnell. Will you state your full name and the connection for which you appear?

Mr. Smith. My name is Russell Smith. I am the legislative secretary of the National Farmers Union.

Senator Donnell. You do not have a written statement?

Mr. Smith. No, sir. May I explain?

Senator Donnell. Yes; if you will.

Mr. Smith. Our witness this morning was to have been Mrs. Evanson, who is the director of education of the North Dakota Farmers Union. She has evidentally missed her plane connections and didn't arrive.

Senator Donnell. Did she file a statement with this committee?

Mr. Smith. No, sir. She has been trying to get here with her statement by plane.

Senator Donnell. Do you want to testify or do you want to wait?

Mr. Smith. I should like to say something briefly and then if the committee has time and she arrives before the hearing closes this week, I hope she will be heard.

Senator Donnell. You understand, Mr. Smith, under the present law statements should be filed in advance so the members may have an opportunity to study them. Also, we have permitted two witnesses from one organization without any knowledge—on my part, at any rate—to appear. We can't do that indefinitely on every organization. It is 11 o'clock here now. We just can't permit two witnesses from every organization. If you want to testify while you are here, you are free to do so and we will be glad to have your testimony but I can't assure you we can have both you and Mrs. Evanson. We may be able to; just wait and see what the time brings.

Mr. Smith. I will only take about a few minutes and I will request that if you have time you hear Mrs. Evanson. Thank you.

Senator Donnell. Go ahead.

STATEMENT OF RUSSELL SMITH, LEGISLATIVE SECRETARY, NATIONAL FARMERS UNION

Mr. Smith. I merely wish to reiterate the views that I expressed last year on behalf of the National Farmers Union, and generally, that is, we support Senator Murray's bill, S. 545.

Senator Donnell. You mean S. 1320?

Mr. Smith. I am sorry.

Senator Donnell. Unless he has been converted.

Senator Murray. Not by any means.

Mr. Smith. I should be deeply disappointed if he had been converted. We believe principally—our principal reason for supporting that bill is that we believe it will be of more benefit to the farm people than any other type of bill that is now before Congress. We think the principle of universal coverage is far more important in rural areas than it is in urban areas. We do not oppose unequivocally any other bill, however. I would like to make it clear if we cannot get a national health insurance program, we believe that some good will be done by the other type of bill. Therefore, I don't want to be in a position of saying flatly that we oppose any bill.

We do believe that farmers would benefit a great deal more from that type of legislation invited in Senator Murray's bill than in the Federal-aid bill. The reasons are obvious. That is, the population in rural areas is very widely scattered. The expense of trying to cover them through Federal-aid plan and through what is called the "means test" plan—the cost would be extravagant in proportion to the aid received. We feel there would undoubtedly be an inclination on the part of the States to skimp insofar as expenditures in rural areas are concerned. In fact, they would almost be compelled to if they were going to do anything to amount to anything with the money in the urban areas.

We believe, too, that the principle of requiring assistance to be made on the basis of economic need is one that presents more complications than could be overcome, and we think, also, it is rather obnoxious to the individuals involved and that most of those who need it most will not get it.

I think that is all that I wanted to say directly, Senator.

Senator Donnell. That is a very direct statement. Senator Murray, do you have any questions?

Senator Murray. None.

Senator Donnell. We have been very glad to have you. When this lady arrives, let us know, and if we can fit her in on the program we will be very happy to do so. We simply have a limitation on our time. Another group will meet in this room this afternoon, for instance, and, therefore, we have to limit the number of witnesses.

Mr. Smith. I appreciate your courtesy.

Senator Donnell. Before Senator Murray leaves, I should like to offer into the record at this time the minority report referred to by Mr. Biemiller, and I will ask the clerk of the committee to advise Mr. Biemiller that it has been offered into the record, so that if he desires to make any comments on it he may do so. I am referring to an American Medical Association report of 1932, being so-called minority report No. 1, by Dr. Christie and others. I call particular attention to the language in that report as printed in Medical Care for the American People, published by the University of Chicago Press, on pages 164 and 165:

> It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience; that is, a compulsory plan under governmental control.
>
> Before doing so, however, we should carefully examine this plan as it operates in Europe at present and face the objections to it. It should be remembered that compulsory systems of health insurance in European countries are still under trial. There is still no convincing proof that under these systems the costs of medical care have been reduced nor that the new evils to which they give rise are preferable to those which they are supposed to abate. The statement that most of the physicians in England prefer not to go back to the system under which they practiced before is not convincing, because the system under which they practiced before was one of widespread voluntary insurance.
>
> The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay-controlled organizations. Such competition tends to lower the standard of medical care, degrade the medical personnel, and make medical care a business rather than a

profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance. The results named above are prevalent in many States. This is the rule to which there are a few notable exceptions. Under workmen's compensation groups are soliciting contracts, often through paid lay promoters; laymen are organizing clinics and hiring doctors to do the work; standards of practice are being lowered; able physicians outside of the groups are being pushed to the wall; the patient is coerced by his employer to go to a certain clinic; and the physician is largely under the control of the insurance companies. These are not visionary fears of what may happen but a true picture of widespread evils attending insurance practice. We should need no better example of what must happen to medical care if compulsory insurance is extended to families.

Senator DONNELL. You will be sure to notify Mr. Biemiller this has been read into the record. The report was not in my possession at the time Mr. Biemiller testified.

(The report referred to follows:)

MINORITY REPORT NO. 1

By A. C. Christie, M. D., George E. Follansbee, M. D., M. L. Harris, M. D., Kirby S. Howlett, M. D., A. C. Morgan, M. D., N. B. Van Etten, M. D., A. M. Schwitalla, Ph. D., Olin West, M. D., and Robert Wilson, M. D.

OUTLINE

I. Organization of medical services.
    1A. Community medical centers.[1]
    1B. Industrial medical service.
    1D. Utilization of subsidiary personnel.
    1E. Private group clinics.
        Other disadvantages to the physician in group practice.
    1F. Pay clinics.
    1J. County medical society clinics.
II. Group payment for medical service.
III. Recommendations of the minority.
    1. Government and community participation in medical care.
    2. Care of the indigent sick and injured.
    3. Coordination and control of medical services.
    4. Restoration of the general practitioner to the central place in medical practice.
    5. Corporate practice of medicine.
    6. Trial of new methods.
        Plan for treatment of chronic diseases.
    7. Development by State or county medical societies of plans for medical care.
IV. Conclusion.

The minority group of the committee whose names are subscribed to this report are in accord with the majority of many of their conclusions and recommendations. We find ourselves, however, in conflict with what we conceive to be the general tone or trend of the report and in certain instances in sharp disagreement with the recommendations for future action. We have also certain constructive suggestions to make which have been omitted or the importance of which has not been sufficiently emphasized in the report of the majority. We regret the necessity for a minority report, but we are convinced that we would fail in our duty both to the public and to the medical profession if we did not point out as forcibly as possible what we conceive to be unwise recommendations or omissions in the majority report of this committee.

We are in full and hearty accord with the majority in its recommendations for the the strengthening of public health services and basic educational improvements, and we agree to some extent with the pronouncements of the committee in respect to coordination of medical services. The first effect of "strengthening public health services" will be a considerable increase in the total cost of medical case, but we have the hope that eventually great savings will come from decrease in the incidence and duration of certain diseases.

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[1] These sections bear the same numbers as the corresponding sections of the majority report.

Some of the recommendations for coordination of medical services and for basic improvements in medical education are immediately practicable and will undoubtedly result in reductions in the costs of medical care. They are in line with the general progress of medicine and are based on sound experience. Many educational improvements are under way through the initiative of the medical and dental professions and college authorities. Among them one of the most important is the increasing emphasis upon the necessity for more thorough training of the general practitioner in all of those fields which only he can adequately fill. In this connection we call attention to the fact that neither scientific medicine nor the organized professions have been unprogressive. They have assumed initiative and have maintained leadership in the advancement of scientific knowledge and in improving the methods of its application to human welfare. In the opinion of the minority the general trend of the majority report makes it appear that the medical profession has been static and unprogressive. This implication we believe to be unjustified by the history of medical progress.

We are in sympathy with the recommendations of the majority which deal with the better training of specialists and their proper control. This is another matter in which the medical profession has taken the initiative. There are already several specialties which have organizations for the certification of specialists. Extensive plans are being perfected by some State medical societies and by the American Medical Association looking to establishment of control of specialism. It should be remembered that specialism has made great contributions to medical progress. Its abuses are capable of control by the professions without any revolutionary changes.

We repeat that this minority is heartily in accord with the majority recommendations with respect to public health and progress in medical education.

With regard to the majority recommendations Nos. 1 and 3, dealing with organization of medical services and group payment for medical service, the convictions of this minority are so divergent from those of the majority that they must be discussed in detail.

I. ORGANIZATION OF MEDICAL SERVICES

The minority group recognizes the desirability of better correlation of the activities of the professions and it is in agreement with the majority upon some of the suggestions under the above heading. There is nothing, however, in the facts elicited by the committee nor in the general experience of the medical professions to lead us to believe that organization can accomplish what is claimed for it in the majority report. On the contrary, it seems clear to us that many of the methods advocated will give rise to new and greater evils in the attempt to cure existing ones. Our views are set forth below under each heading of the majority report.[2]

1A. Community medical centers

The emphasis placed upon this plan which is called the committee's most fundamental specific proposal we believe to be far beyond any possibility of its ultimate value. It is admittedly an idealistic plan based almost solely upon theory. There is nothing in experience to show that it is a workable scheme or that it would not contain evils of its own which would be worse than those it is supposed to alleviate. Above all there is no evidence to prove that it would accomplish what ought to be the first object of this committee, the lessening of the costs of medical care. The plan is suggestive of the great mergers in industry, the main medical center being in the nature of the parent holding company governing the activities of subsidiaries and branches. The idea that size and power are synonymous with excellence and efficiency has received some severe blows during the current economic depression, and opinions concerning it are undergoing revision.

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[2] *Additional statement by member of minority group.*—My major objection to the recommendations of the majority is against group practice and not against group payment. I favor group payment in the compulsory, as opposed to the voluntary, form. But I oppose group practice. From Publication 27 we learn that 40,000,000 people of the United States live in rural areas and in towns of less than 2,500 population, where there are no hospitals around which to form group clinics and where there are not enough physicians, dentists, and other professional personnel out of which to form group clinics that could furnish complete medical care. Therefore, I would recommend that in all such communities every family be urged to select a family physician to whom shall be submitted all health problems as well as illness problems; that we urge the cooperation of this family physician with available laboratories, specialists, etc., the free use of all such whenever needed and the close coordination of such service in rendering adequate and complete medical care. This would preserve the essential personal relationship between physician and patient and restore the private general practitioner to his rightful place as the keyman in any effective system of rendering medical service. I consider this kind of cooperation better and fairer to all parties than the organization of such personnel into partnership groups.—Kirby S. Howlett.

The medical center plan is the adoption by medicine of the technique of big business, that is, mass production. It seems almost impossible for those who are not engaged in the practice of medicine to understand that the profession of medicine is a personal service and cannot adopt mass-production methods without changing its character. It is always the individual patient who requires medical care, not diseases or economic classes or groups. The neglect of this principle in other fields has brought serious evils that are now being corrected only with great difficulty. When mass operation revolutionized industry, social movements tended to follow the industrial pattern. Even education took on many of the factory forms. Educators, social workers, and penologists are now all emphasizing the value of individual case work. Yet in none of these fields are the problems so intensely personal and individual as in that of medical diagnosis and treatment. Nowhere is there greater need of complete liberty of action and close continuous knowledge of the person to be treated nor greater necessity for confidence than in the relation between patient and physician. Medicine has accepted the modern idea of cooperation but has rejected the competitive, mass-production idea of the factory system as being destructive of the social values developed by professional traditions.

Among the many objections to the medical center plan which must occur to anyone familiar with the requirements of medical practice are the following: (1) It would establish a medical hierarchy in every community to dictate who might practice medicine there. This is inherent in the plan since any new member of the center must be chosen either by the chief or by a small staff. (2) It would be impossible to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers. This would add to the evils of medical dictatorship those of a new bureau in the local government with its attendant cost. (3) Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions.

We look upon this plan as far-fetched and visionary. It has no practical relationship to the question the committee has set itself to solve. Placed as it is at the very beginning of the committee's recommendations it must create a doubt of the committee's grasp of the problem to which it has addressed itself. It seems to us an illustration of what is almost an obsession with many people, namely that organization can cure most, if not all, human ills.

1B. Industrial medical service

It is our opinion that this question, which is of great importance, has not been adequately nor fairly dealt with in the majority report. The publications of the committee (Nos. 5, 18, and 20) which describe existing industrial medical services fail, in our opinion, to give a true picture of conditions as they exist throughout the country. For each of these favorable reports many instances could be cited of industrial medical services where the results have been exceedingly unfavorable. These are types of contract practice which have been a source of controversy for many years. The judicial council of the American Medical Association defines "contract practice" as follows:

"By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

It should be remembered that the medical profession does not object to contract practice per se but only to the unethical practices which may attend that method of rendering medical services. There are numerous conditions under which it may be ethical for physicians to enter into contracts to furnish medical care. In isolated mining or lumbering camps medical service can be had only by entering into contract with some physician. Under workmen's compensation laws in some States employers and insurance companies are compelled to provide medical care in such a way that it can be secured only by some form of contract. This came about because workmen's compensation laws in most States were written without regard to the character of medical service under such laws. Defects in the laws are gradually being corrected to provide for a better quality of medical service. Another type of contract practice which cannot be considered unethical is that in isolated communities or sparsely settled rural districts where medical service can be secured only by contracting with a physician to pay part or all of his compensation.

Contracts must be considered unethical and injurious both to the public and to the physician when any of the following features prevail: (1) When there is solicitation of patients, either directly or indirectly. (2) When there is competition and underbidding to secure the contract. (3) When the compensation is inadequate to secure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of physicians is prevented. (6) When the contract because of any of its provisions or practical results is contrary to sound public policy.

Contract practice has been in existence in the United States for many years and lately under the influence of poor economic conditions and the pressure of promoters is becoming widespread. Its chief features are summarized as follows by R. G. Leland:[3]

"(1) Took its origin largely from necessity (isolated conditions); (2) has been legalized in certain places by State statute; (3) under certain conditions and in some forms is both ethical and legitimate; (4) in general, has become highly commercialized and competitive; (5) is largely limited to the pay-roll class; (6) does not, in most cases, extend its provisions to women and children; (7) confines itself, almost without exception, to curative medicine and does not include preventive measures; (8) shows no interest in public or individual welfare; (9) furnishes medical care which is often inferior in character; (10) in many instances is characterized by underbidding, subletting, misrepresentation and racketeering; (11) is economically unsound in many of its present forms; (12) is essentially sickness insurance, usually not supervised or regulated; (13) is often used by the operators thereof to influence legislation in favor of extension of the plan; (14) in many of its present forms, lowers the confidence of both individual and the public in the medical profession; (15) has some features that deserve refinement and extension and others that are unethical and dangerous and should be abolished."

So many abuses have always attended nearly every form of contract practice that the minority is willing to recommend it only when the objectionable features named above can be eliminated.

One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice is that there has been found no means of preventing destructive competition between individuals or groups concerned with these movements. This injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service.

One of the pernicious effects of contract practice schemes is that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practice, but as new ones are formed the barriers are gradually broken down in order to secure business.

There are general objections to all such methods of furnishing medical care which have been pointed out by representatives of organized labor. They are essentially paternalistic in their operation, giving to the management of industries an increased control over their employees. The intrusion of the company employed doctor into intimate family relationships is objectionable. Privacy and the personal relationship which should exist between patient and physician are broken down. The records of the patient's illness are in the files at the disposal of the company officials. Free choice of physician is absent; coercion is inevitable. Fear of loss of his job compels the employee's consent to the plan and to the doctor furnished by the company.

It is the belief of the minority group that the majority report has presented this entire question in a distorted manner. The evils of contract practice are widespread and pernicious. The studies published by the committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found. The evils are inherent in the system although they may be minimized when a high grade personnel is found either among employees or medical group, or both.

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[3] Journal of the American Medical Association, March 5, 1932, vol. 98, pp. 808–815.

Any method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation, or which breaks down its ethical standards or furnishes inferior medical service, must be condemned. It is hardly open to doubt that contract practice, as usually carried on, is such a method.

Industrial medicine as it operates under workmen's compensation laws is further discussed below under Group Practice.

1D. Utilization of subsidiary personnel

This recommendation is nothing new in medical practice. It has already developed along many lines through the initiative of the medical, dental, and nursing professions. We need cite only the widespread employment of technicians in clinical laboratories, the use of dental technicians and hygienists both for laboratory and clinical work, and the extension of nursing service. In radiological departments in hospitals, clinics, and private practice important duties have been assigned to technicians, and their services are being widely utilized. Even in those fields specifically mentioned by the majority report there have already occurred many advances in the directions recommended. We wish to add a word of caution relative to the dangers involved in permitting nonmedical technicians to assume the duties which only physicians should undertake. There is constant temptation in many fields to permit technicians to perform duties entirely unjustified by their knowledge and training. Deterioration of service invariably results from such practice.

1E. Private group clinics

We believe the establishment of such clinics is in line of progress when they are a natural outgrowth of local conditions. It is the belief of the minority group that the majority report gives far too much importance to the value of this type of medical practice. That it has accomplished generally or can ever accomplish what is there claimed for it is open to grave doubt. There is nothing in our own experience nor have we been able to find anything in the committee's studies to lead us to conclude that group practice can furnish, in general, better or cheaper medical care than we have at present. In cities above 100,000 in population the multiplication of groups results in duplication of laboratories, expensive equipment, and overhead charges which make the system not less but more expensive than the present method. It usually results not in fewer specialists but more, because each group feels that it must have a representative of each important specialty. Even if it were possible to preserve the personal relationship of physician and patient in group practice, which is admittedly difficult, the method has only limited applicability. We wish to call attention to the fact that the studies published by the committee on private group clinics were far too few in number to constitute a safe base upon which to erect so large a structure as is proposed. This is especially true since no evidence is produced to indicate lower costs to patients. The studies of the committee which show 40 percent overhead in the practice of private physicians and 15 to 25 percent for groups fail to tell the whole story. It must be remembered that groups usually offer only partial service and that when full domiciliary care is offered it is often provided through young and inexperienced doctors on a low salary. Costs can always be reduced through a restricted or inferior service. The most important discrepancy in conclusions drawn from the above studies arises from failure to consider the fact that multiplication of clinics or groups in large communities results in provision of expensive equipment far beyond the needs of the community. It serves no good purpose to reduce overhead in individual clinics if the total cost to the community is increased through duplication of plants.

The establishment of groups within recent years in many cities throughout the United States to treat patients under workmen's compensation laws or under contracts made with employers or groups of laymen has resulted in many abuses. Such groups are now in competition with each other, many of them openly soliciting patients through paid agents, many of them controlled by laymen and most of them constantly trying to keep down the cost of operation by employing physicians of inferior ability. Such groups, now scattered all over the United States, are rapidly resulting in the commercialization of medicine and the destruction of professional standards. Under such a system the tendency is to reduce medicine to the status of a competitive business instead of a profession with high ethical standards.

It is not our contention that all group practice has the above results but only that many groups have already been formed to practice under the commercial arrangements indicated. It is important in judging this question to give attention not only to those successful and favorable experiments in group practice cited in the majority report but also to take account of the scores of clinics which have failed and of the large numbers which are at present engaged in a type of practice inimical to every fine tradition of medicine.

Other disadvantages to the physician in group practice.—Except for the heads of the group, freedom of action is restricted in respect to vacations, study, travel, attendance upon scientific meetings, and even publication of medical articles, by the will of the chief or chiefs of the clinic. It is contended by proponents of group practice that the physician can advance in professional knowledge more rapidly if he is assured of opportunities for study and is relieved of financial worries by the group, than is possible in private practice. It was pointed out above that only the chiefs of a clinic have freedom to advance along lines of their own choice. Subordinates are not permitted to pursue any course contrary to the general policies of the clinic. It is also very doubtful if men placed on a secure financial footing by a group contribute any more to progress than do those who are impelled to their best work under the stimulation of individual competition, scientific ambition, and initiative. The income of members of a group, except that of the owner or owners, while fairly stable, is comparatively static. When a salaried employee advances in salary to a point no longer profitable to the clinic, his income remains fixed. He then has the choice of waiting until someone ahead of him, whose place he can fill, dies, or of leaving the clinic and starting to build a practice at a time when he should be reaping the rewards of experience and ability.

The plans advocated in the majority report involving groups made up of general practitioners and specialists are theoretically attractive but thoroughly impractical. We are still far away from the time when the general practitioner will be accepted by a group of specialists as the correlator of their work.

We wish to make it clear that the above discussion of group practice does not refer to the association of physicians upon the staffs of hospitals nor their contact and consultation in clinics.

Groups of specialists as distinctive organizations are very valuable for diagnosing or treating difficult or complicated cases, but for the 85 percent of illnesses which make up the family doctor's practice better service can be given by the individual doctor in his own office than in a clinic, and at less cost.

It should be remembered that medical groups are subject to financial failure, just as are other business ventures. This has happened repeatedly and is not prevented by having a lay business manager in charge of finances. In periods of economic depression the group with its large overhead first cuts salaries, then discharges employees, both professional and lay, and finally may be forced to close. A frequent cause of failure and disruption of clinics or groups is the death or disability of some able man or men about whom the clinic has been built. When a group is forced to close, the physicians must seek employment in some other group or attempt private practice. The latter is usually very difficult because men in a group usually have little personal following and may have little training to practice general medicine. It should be remembered that patients who go to a clinic are the patients of the clinic and not of any individual doctor. Failure of a group may also have a very injurious effect upon the medical care of the community which is more or less dependent upon it. The private practice of medicine is likely to be a much more stable system, year in and year out, than any system based upon groups. When hard times come and the clinic must keep up its prices to meet its overhead, the private practitioner simply continues to care for his clientele and, with the rest of the community, takes his chances on receiving his pay.

The minority recognizes the advantage of group practice under certain conditions, especially in communities where practically all of the physicians can be joined in one or, at the most, in two groups. It does not believe that group practice offers any real solution to the problems of the cost of medical care except under very restricted conditions. The dangers of group practice are already apparent, and the advantages either to the medical profession or to the public are limited.

1F. Pay clinics

We approve the development of pay clinics when they are under the management and control of physicians and are conducted on a high ethical plane and are needed to meet a situation. The same ethical considerations should prevail in the relations of clinic and patient as are operative between the private physician and his patient. There is no magic in the name "clinic" that can make it ethical for its agents to solicit patients in its name when it is considered unethical for a physician to do so as an individual. The traditions of the medical profession are strongly opposed to advertising and to solicitation of patients. If the ethics of the profession are broken down at this point, inroads will soon be made at other points, and the profession of medicine will degenerate into a competitive business without professional ideals.

When clinics are owned and controlled by laymen, the evils are accentuated. Clinics so owned or controlled result in exploitation of the public and the medical professions and in an inferior quality of medical service or an increase in the costs of medical care, or both. When the middleman enters into the picture, the costs of medical care are always increased and quality is sacrificed. This is true whether the middleman is a layman or a corporation running a clinic, or an insurance company which must charge costs of operation to the patient.

1J. County medical society clinics

The subject is dismissed in the majority report as of little or no importance. The minority believes that this is an important development which may be very valuable in solving the problems of medical care. We discuss it among other specific constructive suggestions offered later.

II. GROUP PAYMENT FOR MEDICAL SERVICE

The committee on the costs of medical care has been in existence for 5 years and during that time has collected at considerable expense a great body of data. Among these data are extensive comments on insurance medicine as it has developed and is now working out in various countries in Europe, and also in this country. In 1931 Simons and Sinai conducted a study of health insurance for the American Dental Association which the majority report of the committee summarizes on page 99. One of the statements in their summary is as follows: "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge to a compulsory system. Every so-called voluntary system is successful in just about the proportion that it contains compulsory features." Nothing has been made clearer than the fact that voluntary health insurance schemes have everywhere failed. In Europe they have been replaced by compulsory systems which are now under trial. Even in Denmark, where the system is nominally voluntary, there are indirect but very effective means of compulsion. In spite of these facts the majority of the committee makes definite recommendations that this country adopt the thoroughly discredited method of voluntary insurance. It is admitted in the majority report on page 125 that there are many dangers inherent in the plan. The principal safeguard against these dangers offered by the majority is to tie the voluntary insurance system up with the visionary medical center plan which they have earlier offered as the "keystone" of all medical service. We have tried to show that such a medical center simply substitutes new and greater evils for old.

It seems clear that recommendations for further trial and expansion of voluntary insurance schemes in the United States are entirely inconsistent with the committee's own findings. To recommend that our own country again experiment with discredited methods of voluntry insurance is simply to ignore all that has been learned by costly experience in many other countries as well as in our own.

Voluntary insurance systems are now in operation in many parts of the United States and are increasing in number and in size. In many places these schemes are being operated in accordance with the plan recommended by the majority of the committee, that is, by making contracts with organized groups of the medical profession. That they are giving rise to all the evils inherent in contract practice is well known. Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical services, loss of personal relationship of patient and physician, and demoralization of the professions. It is clear that all such schemes are contrary to sound public policy and that the shortest road to the commercialization of the practice of medicine is through the supposedly rosy path of insurance.

The careful reader of the majority report will note that not all of those who sign that report are willing to recommend voluntary insurance. Arguments against the voluntary system are forcibly set forth by the dissenters among the majority on page 131.

It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under governmental control.

Before doing so, however, we should carefully examine this plan as it operates in Europe at present and face the objections to it. It should be remembered that compulsory systems of health insurance in European countries are still under trial. There is still no convincing proof that under these systems the costs of medical care have been reduced nor that the new evils to which they give rise are preferable to those which they are supposed to abate. The statement that most of the physicians in England prefer not to go back to the system under which they practiced before is not convincing because the system under which they practiced before was one of widespread voluntary insurance.

The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay controlled organizations. Such competition tends to lower the standards of medical care, degrade the medical personnel, and make medical care a business rather than a profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance. The results named above are prevalent in many States. This is the rule to which there are a few notable exceptions. Under workmen's compensation, groups are soliciting contracts, often through paid lay promoters; laymen are organizing clinics and hiring doctors to do the work; standards of practice are being lowered; able physicians outside of the groups are being pushed to the wall; the patient is coerced by his employer to go to a certain clinic; and the physician is largely under the control of the insurance companies. These are not visionary fears of what may happen but a true picture of widespread evils attending insurance practice. We should need no better example of what must happen to medical care if compulsory insurance is extended to families.

There is one aspect of any system of insurance which should be kept in mind by all students of this question; namely, that the total cost of medical care is usually increased when it is paid for through insurance. There are two reasons for this. First, the cost of operation of the insurance plan must be added to the cost of medical care. The majority report recognizes this by the following statement on page 50: "The participation of insurance companies in the forms of insurance against the costs of medical care which are recommended in this report would, the committee believes, tend to increase the costs and not to improve the service." The majority report, therefore, approves of insurance but disapproves of insurance companies. This means, of course, that the majority report favors some form of insurance through a nonprofit organization. The minority agrees that this principle should always govern in any plan of contract practice that may be necessary to meet the needs in a particular situation. The patient's fees will then be available for the costs of medical care, aside from the necessary costs of administration. The second reason for the increased cost of medical care under insurance systems arises from a fact which has been thoroughly demonstrated; that is, the number of persons sick and the number of days' sickness per capita always increase under any system of insurance. This is shown to be true for European countries by Simons and Sinai and has been demonstrated in relatively small health-insurance projects in this country. "Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seems to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance."[4]

We are not here attempting to marshal all of the facts or arguments that can be used against health insurance. Innumerable articles have been written on the subject. No absolute judgment is possible at the present time with regard to what place, if any, insurance should finally have in helping people to pay for medical care. We have tried only to show here that there are great dangers and evils in insurance practice which must be set over against the advantages of distributing the costs of medical care by this method and which, it seems to us, the majority report has minimized. The dangers are especially directed at the continued well-being and progress of the medical professions, which, after all, are the ones most concerned in maintaining a high grade of medical service. It ought to be remembered that compulsory insurance will necessarily be subject to political control and that such control will inevitably destroy professional morale and ideals in medicine. Since a qualified and untrammelled medical profession is the only agency through which scientific medicine can be applied for the benefit of the people, it follows that any plan which destroys professional morale will bring disaster to the public. One of the conclusions of Simons and Sinai [5] is of especial significance in this connection. "While the statement might be disputed by insurance societies, a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are entrusted to the medical professions." This statement is both a challenge to the medical profession and a warning to those who, without proper consideration of that profession, are willing to recommend the adoption of various new plans for the care of the sick.

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[4] The Way of Health Insurance, A. M. Simons and Nathan Sinai, p. 157.

It is our conviction that the Committee on the Costs of Medical Care would have served its stated purposes and the cause of medical progress and the people's health much better if it had taken a strong stand against all of those methods of caring for the sick which have in them the dangers and evils of "contract practice." By doing so they would have come to the assistance of the medical profession in a battle against forces which threaten to destroy its ideals, disrupt its organizations, and completely commercialize its practice, and which are at the same time opposed to the public welfare. The medical profession is now in many parts of the country extending and perfecting plans through which it can offer to the people in a more systematic way the services of all the physicians of each community at prices which all the people can afford. It is only by including all of the members of the medical profession of a community that the abuses under insurance systems may be avoided. The nature of some of the plans is indicated under the minority recommendations below.[6]

III. RECOMMENDATIONS OF THE MINORITY

The minority group in offering the following recommendations has tried to keep in mind the main object which called this committee together; namely, to find some solution for the problem of furnishing good medical care to all the people at prices which they can afford. We have no delusions that our recommendations, even if fully put into effect, will solve all the problems of medical care. We have tried to approach the problem from a practical standpoint and to suggest progressive changes in the present system rather than to offer new methods based largely on theory and revolutionary in their practical application. We believe that our viewpoint is divergent from that of the majority in this respect. We are not opposed to progress nor to the adoption of new procedures. We are especially concerned, however, that new procedures be based upon sound experience and that in adopting them we do not lose the values that have been accumulated through the centuries. It is true in medicine as in all other fields of human experience that the soundest and most lasting progress is brought about slowly and step by step. Medical practice in the United States is progressing in this manner. We believe this to be the truly scientific method. We are loath to adopt revolutionary theories, however attractive they may seem, which may have within them the seeds of more harm than good.

It has been stated in the majority report of this committee that we must plan 20 to 50 years in advance. We doubt our wisdom to do this. If society changes as rapidly in the next 50 years as in the past 50, it seems presumptuous to assume that we can foresee conditions or needs sufficiently clearly to plan so far in advance. It is not too soon, however, to plan for the profession which is to furnish medical care a generation hence. If that profession is to attract young men of ability and high ideals, the great traditions of medicine must be preserved. We repeat here what we have stated earlier in this report that reductions in the cost of medical care which are obtained at the cost of degrading and demoralizing the professions upon which the people must depend for that care are far too costly to be of real value.

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[5] Loc. cit., pp. 206–207.

[6] *Dissenting statement by members of the minority group.*—We are not in entire agreement with the above condemnation of compulsory health insurance. We believe it may be possible to guard against many of the evils of the system, and that it is worthy of a trial.—Kirby S. Howlet, Robert Wilson.

In making its recommendations the minority has had constantly in mind the first postulate set down at the beginning of chapter II in the majority report to which we unreservedly subscribe. It is as follows: "The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician."

The term "personal relationship" used so frequently throughout the committee's publications and in the final report conveys but a vague meaning as to its essential elements and the reasons for its emphasis.

By personal relationship is meant that bond of sympathy and interest in the patient's welfare on the part of the physician; confidence in the ability, integrity, and discretion of the physician on the part of the patient: and mutual regard on the part of each for the other which cause the patient to disclose for the purpose of diagnosis and treatment the most private and confidential information concerning himself and his surroundings when necessary for proper diagnosis and treatment. The character and personality of the physician is a major factor in its development and in process of time and continued contact as patient and physician a friendship and intimacy develop that assumes priestly characteristics on the part of the physician—the characteristics of the confidant and adviser in the most intimate personal and family relationships. All phases of personal and family life are at times closely related to the diagnosis and care of an individual's condition, and economic and financial conditions are often as important in diagnosis and care as physical or mental abnormalities. It is an individual relationship, the product of character and personality, and cannot be transferred to a group or fostered by group practice.

It is our belief that the majority report in many of its recommendations for group practice and group purchase and in its emphasis upon what may be called mass practice instead of individual practice has completely lost sight of this primary postulate.

Our recommendations are based upon the conviction that the medical profession is the essential element in the furnishing of medical care. Its influence should be upheld and strengthened and every assistance given to it to maintain its high professional standards. They are based upon the further conviction that the general practitioner is the most important factor in the medical profession and that he can function effectively only through the maintenance of private medical practice.

1. Government and community participation in medical care

Many of the difficulties of the medical profession and a part of the problems of the costs of medical care to the moderate-income groups would disappear if local and national governments and communities in general were properly fulfilling their obligations. On the one hand, there is failure to assume the full care of the indigent and, on the other, there is usurpation of the field which should be reserved entirely for private practice.

Recommendation 1.—The minority recommends that Government competition in the practice of medicine be discontinued and that its activities be restricted (*a*) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (*b*) to the promotion of public health; (*c*) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other Government services which cannot because of their nature or location be served by the general medical profession; and (*d*) to the care of veterans suffering from bona fide service-connected disabilities and diseases, except in the case of tuberculosis and nervous and mental diseases.

We stated early in this minority report that we heartily endorse the recommendations of the committee which deal with strengthening of public-health services. We emphasize especially the following points: (1) The need for more adequate training of medical students in public-health matters; (2) the elimination of politics from public-health administration; (3) improved standards in public-health services to make them more attractive to able men; tenure of position should be more secure and remuneration should be increased.

It is our belief that Government should not extend its activities into those fields which can be effectively covered by the private practice of medicine.

We wish especially to emphasize our recommendations that the governmental care of veterans for general medical and surgical conditions be restricted to bona fide service-connected disabilities and diseases. The supply by the Government of hospital facilities necessary to care for the more than 4,000,000 veterans with their increasing disabilities as they advance in age will constitute a colossal waste. Last year from 25 to 40 percent of the beds in civilian hospitals throughout the United States were empty. There is good evidence to show that all veterans can be taken care of in existing hospitals if nonservice-connected disabilities are treated in civilian hospitals. The treatment of veterans by the Government for non-service-connected disabilities has resulted in hardship to the medical profession by withdrawing many patients from private practice. The waste incident to the transportation of veterans back and forth between their homes and Government hospitals is enormous. It is advantageous to the veteran to be treated near his own home by the physician of his own choice. This is especially important in acutely urgent diseases. We believe that the law providing the Government treatment of non-service-connected disabilities should be repealed.

2. Care of the indigent sick and injured

It should be recognized that it is the duty of the state to give complete and adequate medical care to the indigent. One of the greatest burdens on the medical profession today is the care of the poor. Many communities provide hospital care for the indigent when they need it, although even this is not fully provided for in most communities. The full burden of the professional care of indigents not only in their homes but also in hospitals and clinics is thrown upon the medical profession. Attempts have been made to estimate the money value of the free service performed by the doctors of the country each year. It is practically impossible to arrive at anything definite by such attempts. It is known, however, that the medical profession has always performed this service without pay and few communities have ever recognized any obligation to relieve them from it. It is obviously a burden which should be borne by the entire community and not by the medical profession alone. The doctor should bear his share like any other citizen through payment of taxes and support of the local community chest and other charitable agencies, but he should be paid by the community for his professional services to the indigent. The only exception to this should be where he renders services in an institution in which he receives his compensation in added prestige and experience. The community should also bear the total cost of hospitalization, nursing, etc., of every indigent person.

Recommendation 2.—The minority recommends that Government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

If such a plan were made effective, its results would be far reaching. The income of physicians would be increased. The young doctors would benefit especially because it is always in the first years of practice that a doctor treats the largest percentage of charity patients. Such a plan, effectively carried out, would have a definite effect upon the cost of medical care to those who can pay for it. It would result in reduction of cost of hospitalization of pay patients because at present the patient must pay not only for his own care but in addition a certain proportion of the cost of the care of the indigent. It would be much more reasonable to determine whether or not communities can and will pay for the cost of medical care for their indigents, who are logically a charge against it, before plans are tried to compel the community to bear the costs of sickness of those who have incomes.[7]

3. Coordination and control of medical services

This is one of the recommendations of the majority with which we are in general accord. We wish to emphasize further the importance of putting these measures into effect in the immediate future. Much waste can be eliminated in our present system by the coordination of our present agencies and methods. The minority group recommends as a permanent coordinating body the agencies listed in the majority report. In order to initiate a progressive program for cities, counties, or States the appropriate medical, dental, and pharmaceutical societies and hospital associations should appoint committees to ascertain the facts regarding the provision of medical service, to study the various possibilities for extending the service, and to prepare local or State plans accordingly. We agree with the majority that "to provide a full and balanced view of problems and needs, to contribute administrative experience, and to give added weight to recommendations such committees should include informed persons as associate members or should establish cooperative relations with representatives of appropriate public organizations such as community chests. * * * The community may properly look to its physicians, dentists, and other persons who have a full-time interest in the problems of medical economics to furnish dynamic leadership in community planning." We wish to emphasize the fact that medical and dental professions and hospital associations have already in many localities initiated movements intended to coordinate medical service. The success of these movements is likely to be in direct proportion to the degree of interest exhibited by the local professional organizations. They must increasingly assume responsibility for initiation and guidance of efforts in this direction.

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[7] *Additional statement by member of the minority group.*—While accepting in general the principle of the state responsibility for the indigent, I cannot regard the responsibility as exclusive, since by such a policy the economic, social, and spiritual benefits to the public derived from private and voluntary philanthropy and charity would be endangered.—A. M. Schwitalla.

These first three recommendations seem to us the first steps that should be taken in dealing with this problem. Their widespread adoption would eliminate so much waste from our present system that the problem would immediately take new and less urgent aspects.

4. Restoration of the general practitioner to the central place in medical practice

The next logical step after the three named above is further elimination of waste by increasing the efficiency and extending the field of the general practitioner of medicine.

Recommendation 4.—The minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

This, of course, is quite the opposite of the majority's recommendations for concentrating medical practice in groups and medical centers. The majority report of the committee recognizes and emphasizes the extremely personal nature of medical practice. In the summary volume, chapter XXIII, is found the following statement: "It (medical care) is also a personal service involving individual relationships between a medical practitioner and a patient. * * * The personal nature of disease and of medical care is the foundation upon which the economic organization of the past has been constructed, and must be the basis for expansion or reconstruction of the future. To ignore or deny the significance of this personal element in the economic organization of medical care would be as absurd as to overlook the laws of mechanics in the construction of a bridge." We have no doubt of the truth of the above statement nor of its fundamental importance. It contains the reason why we are opposed to all forms of medical practice which make it difficult or impossible to maintain the personal relationship of physician and patient. This is one reason for our insistence that the general practitioner must be kept in a central and important place in medical practice. Neither do we agree with the majority that savings in the cost of medical care are to be made by eliminating the general practitioner or submerging him in a group. Experience has taught us that the opposite is true. In a group the general practitioner tends to disappear. The great majority of illnesses and injuries (about 85 percent) are of such nature that they can be treated efficiently by any able general practitioner with very simple equipment. In fact, the general practitioner does not need elaborate apparatus of any kind. His most important items of expense are his means of transportation and his rent. Neither of these can be greatly affected by combinations of general practitioners in groups. The organization of a group of 15 to 25 men results in increase in expense to the community, since the group must have complete apparatus for all branches of medicine, whereas before they were joined in the group the entire 15 to 25 utilized the X-ray and other laboratories already established in the community. Theoretically, there seems to be economy in group practice, but practically this is true, as has already been pointed out, only in small communities where only one or two groups are necessary for the entire community.

Efforts, then, should be directed not to the elimination of the general practitioner but to the preparation of students in medical schools better to fill the important place that he has always occupied. The primary object of medical education should be to develop general practitioners. It is not that medical courses must become longer and more difficult, but that the emphasis must be changed. The general practitioner is quite capable of taking over many of the procedures now assumed by specialists, and should do so. It is not only in the field of diagnosis and therapy that the emphasis is changing, but it is now recognized that the general practitioner has a wide field in the prevention of disease.

Instruction in this field should be improved in professional schools. In a word, the general practitioner must be equipped to render good medical service to the families in which he becomes the trusted medical adviser.

Along with a change in the basic education of general practitioners must go better training and better control of specialists. As has already been stated, specialism has added much to medical progress. It needs now better control in order to fit it into our present life. Among specialists, group practice works to advantage and will eliminate some sources of waste.

5. Corporate practice of medicine

A number of corporations have been formed in different parts of the United States for the purpose of selling the services of physicians to the public. Many of them include some type of insurance scheme. It is our belief that these schemes of laymen to exploit the medical profession and the public are a logical outcome of the many insurance schemes which have preceded them in this country and abroad. They are simply a further step in the commercialization of medicine. Their nature is clearly shown by the statement of one of them concerning the distribution of each dollar paid for medical care. Of each dollar, 45 cents is set aside for medical care not including hospital charges, 12.5 cents is for hospitalization, the remaining 42.5 cents goes to the company.

Some universities and some hospitals have capitalized the reputations and services of their professors in medicine or their staffs, charging fees commensurate with the ability of patients to pay for the professional services rendered by this essential personnel. The excess of fees collected above the salaries paid is a direct profit to the institutions and is derived from a personal service which the law permits to be rendered only by an individual who is duly licensed to deliver and charge for such service. In some hospitals, the physician renders his services without salary or other emolument except the prestige of a staff position.

This minority group is opposed to all such schemes and offers the following recommendation:

Recommendation 5.—The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

6. Trial of new methods

Many experiments are being tried at various places throughout this country to assist the people in dealing with the economic aspects of sickness.

Recommendation 6.—The minority recommends that careful trial be given to methods which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

There are many plans developing at present which seem to us proper evolutionary developments and have the great advantage of being immediately practicable. They embody no revolutionary changes which might interfere with medical progress in the future. We note that the majority report minimizes the value of some such plans because they are only palliative. We look upon this as an argument in their favor. Objection to so-called palliatives, which with other like measures may relieve conditions so that no radical procedure is needed, would be similar to the surgeon refusing minor surgical or medical treatment on the ground that it might prevent a major operation.

Plan for treatment of chronic diseases.—We call attention to a plan for treatment of chronic diseases which tends to improve quality of service, regulates the expense of treatment, and distributes the payments over a period of time. This plan is applicable under individual or group practice and has no objectionable features.

Under the system of charge per visit many chronic diseases do not receive adequate care. There are two major reasons: (1) indifference or ignorance on the part of the patient, and (2) economic reasons.

Indifference.—The development of chronic diseases is often so insidious as to result in a precarious condition of the patient before his trouble is brought to his attention. He is faithful in attendance and in following instructions until, in his own opinion, his trouble is cured or sufficently relieved to need no further attention, and he postpones or stops coming for periodical check-up, either because he feels it not needed or because he objects to paying for visits which only assure him he is getting along properly or needs but minor changes in his routine. He therefore ceases to be under observation and control and soon returns to his former precarious condition. The treatment must then be carried out all over again, with its loss of time, increased expense, and advancement of the pathological condition. Often the patient does not return to the former physician and the necessary process of diagnosis and inventory must be repeated at additional cost and loss of opportunity to the patient. With continuous complete service for chronic diseases paid for on a yearly basis the temptation to relax in care would be largely removed.

Economic reasons.—Only a small portion of the service necessary in the care of chronic diseases can be paid for by the majority of the people under the fee-per-visit system of charging, and one of the following conditions results: (*a*) The patient discontinues his treatment because be cannot pay and does not wish charity; (*b*) the patient continues to receive treatment and runs a bill which he can probably never pay; (*c*) the physician takes care of him as a charity patient after he has been charged the amount he can afford; (*d*) the patient is sent to a dispensary after he can no longer pay his doctor. This situation is bad for both patient and doctor, since the former needs continuous care by the same doctor and the latter desires to study and treat the entire course of a disease and not an isolated incident in it.

A satisfactory solution of this problem is found in the application of the following philosophy of practice. The doctor has knowledge and skill for sale. If he desires to treat patients with certain diseases, he must familiarize himself with the vagaries of these diseases and must possess the necessary equipment and skill in its use to perform all the necessary service. If the essential knowledge and skill is beyond the capacity of one individual then the one desiring to give the major part of the service must ally himself with others giving the needed supplementary services, and must pay them for this service, charging the amounts so paid to his office expenses.

No patient should be charged separately for a visit or any particular part of the service, but for all of it, no matter what it comprises. Since chronic diseases need continuous supervision of the patient by the doctor the application of this principle requires that chronic diseases be treated for an inclusive fee to cover complete medical service for that disease for a definite period of time. This fee should be assessed on a sliding scale in accordance with the patient's financial circumstances, with a minimum just above the charity level and a maximum comparable to the fees now paid by the wealthy. This fee should bear no relation to the number of visits or the type of service rendered. Practice under this plan has been carried on since 1929 in The Asthma and Hay Fever Clinic in Cleveland with satisfaction both to doctors and patients.[8]

Payment under this plan can be made in advance or on a series of deferred payments as agreed to by the patient and physician. The former knows what his year's care will cost and need not worry over the number of visits or "extra" services. The latter has agreed to and knows just what he is to receive and when he will receive it. Relations between patient and physician are not subjected to any strain or reserve on economic grounds under this plan.

Another plan that is being tried extensively is the grouping of physicians' offices in or around a hospital. We agree with the statement in the Summary Volume in chapter XXIV that "the centering of medical service in the hospital, which already represents an important concentration of capital investment and professional personnel, would appear to have practical advantages for physicians, hospitals, and patients." It is opposed to the principles we have laid down, however, for the hospital to control medical practice or to enter into the practice of medicine in any of its branches as an institution.

A caution that is necessary at this point concerns the danger of overhospitalization when all the medical activities are centered around a hospital. A further caution is necessary with regard to establishment of hospitals in localities where there is insufficient or unqualified personnel and where a hospital is not actually needed. The merit of a hospital depends upon the ability of the professional personnel who are charged with its work. It is not brick and mortar but men who make the value of an institution.

7. *Development by State or county medical societies of plans for medical care*

The recommendations we have offered up to this point are concerned with the elimination of waste, the abatement or avoidance of evident evils in present practice, and improvement in the quality of medical care. We have already set forth our objections to the majority's recommendations for adoption of insurance systems. We tried to make it plain that we are not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine.

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[8] The Bulletin of the American Medical Association, June 1931.

Medical societies in various parts of the United States have been giving careful study to the question of the possibility of distributing the costs of medical care and at the same time avoiding the evils of insurance systems.

This minority group agrees that any plan for the distribution of medical costs must have the following safeguards:

1. It must be under the control of the medical profession. (A "grievance board" to settle disputes, having lay representation, is permissible and desirable.)
2. It must guarantee not only nominal but actual free choice of physician.
3. It must include all, or a large majority of the members of the county medical society.
4. The funds must be administered on a nonprofit basis.
5. It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.
6. It should make adequate provision for community care of the indigent.
7. It must be entirely separate from any plan providing for cash benefits.
8. It must not require certification of disability by the physician treating the disease or injury.

This group recognizes the value of trial of plans based upon the above principles by county medical socities. We believe that the county society, approved by and under the supervision of the State and national societies, is the proper unit of organization to attempt such experiments. Report will be found in the committee's findings of various county societies in Iowa which have been experimenting with caring for the indigent as a county society project. Our reasons for favoring thorough trial of the county society plan for furnishing complete medical are are as follows:

1. It places responsibility for the medical care of the entire community upon the organized physicians of the community.
2. It places medical care under the control of the organized profession instead of in the hands of lay corporations, insurance companies, etc.
3. It places responsibility for the quality of service directly upon the organized profession. It is in fact the only plan which guarantees quality of service and makes it the only basis of competition.
4. It removes the possibility of unethical competition because it includes all the physicians of the community and fixes a fee schedule.
5. Solicitation of patients, underbidding for contracts and other evils of the usual insurance plans are eliminated.
6. Freedom of choice of physician is assured and the essential personal relationship of physician and patient is thereby preserved.
7. It is the only plan which includes all classes, from the indigent to the wealthy.
8. It is adaptable to every locality, both urban and rural.
9. It provides for a minimum cost of administration by operating on a nonprofit basis.
10. It provides for payment, by every patient with income, of a certain minimum amount before the insurance is in operation. The minimum rises with the patient's income. This provision alone will operate to avoid many abuses in all other types of insurance practice.
11. It provides for means of certification of disability separate from the attending physician.
12. Cash benefits do not form a part of the plan.

The main objections urged against the plan are that it places too much power in the hands of the organized medical profession, and that county medical organizations will be too lethargic to put the plan into operation.

It is the opinion of this group that it is much better to lodge power in the hands of the professions which are trained to furnish medical care than in the hands of lay corporations. This is especially true when, under the proposed plan, responsibility can be definitely placed on the organized professions for the quality of care furnished. The plan provides for settlement of individual disagreements or complaints by a "grievance board" with adequate lay representation. The objection to the plan on the grounds of lethargy of medical societies should not have great weight. Many medical societies are very active in promoting means for better care of the people of their communities. It is our belief that when the proposed plan has been in successful operation for a short time its advance will be spontaneous and widespread.

It is true that the plan in some essential respects is new, but it is based upon past experience. It is an attempt to distribute the costs of medical care by utilizing the good in insurance plans and avoiding their dangers and evils.

IV. CONCLUSION

The problem of the payment of the various expenses that accompany disease and injury has arisen as a result of developments in the medical field, on the one hand, and of complex changes in the economic and social order, on the other.

Within the past 50 years, as the chairman of the committee has emphasized in his introduction, revolutionary changes have taken place in the practice of medicine because of various important discoveries in the causation, treatment, and prevention of disease. Within that time bacteriology, serology, and the x-ray have developed; hospitals have grown to enormous proportions, nursing has come to occupy a place not formerly thought necessary; specialization is now an important part of medical practice; medical education occupies a far longer time and is much more expensive than formerly; and apparatus for the diagnosis and treatment of disease now requires the investment of a large amount of capital.

Such changes in themselves would have increased the costs of medical care, but the problem has been rendered much more complex by the rapidly changing conditions in society and industry. The population of the United States has changed in a comparatively short time from one predominantly rural to one to which 50 percent of the people live in cities. This means that a much greater percentage of the people is now employed in industries than was formerly the case. Along with this urbanization and industrialization, there have developed radical changes in the standards of living. The luxuries of the late nineties are now necessities of life for great masses of the population. All of these changes, both in the practice of medicine and in society, have operated to cause an increase in the costs of taking care of people when they are sick. There is little doubt that the changes are desirable but it is obvious that they increase the costs of medical care.

It is plain, therefore, that many of the problems which are under discussion are the general problems of a transitional stage in social development and are not peculiar to medicine or medical care. Their solution must depend upon far-reaching social and economic adjustments. They are analogous to the problems which caused great social and political unrest in the last decade of the last century and which were not settled until there was a general increase in wages to compensate for improvements in the standards of living.

It does not seem probable to this minority group that these complex problems can be solved or necessary social readjustments hastened by the widespread adoption of the recommendations of the majority of this committee for the group practice of medicine or group purchase of medical care.

Our understanding of the majority report is that it offers essentially the following type of medical practice in the future: The medical profession is to be formed into large or small groups, preferably large, and these groups are to furnish medical care under some type of contract with groups of laymen, the funds to be furnished by insurance, preferably of the voluntary type. Over against this we offer medical care furnished by the individual physician with the general practitioner in a central place; with groups and clinics organized only where the nature of the situation and character of the personnel render such organization a natural development; with elimination of waste in our present methods and coordination of all existing agencies; with careful trial of new methods based upon sound experience; and with adoption of insurance methods only when they can be kept under professional control and destructive competition eliminated; all of this through a well-organized, untrammelled medical profession true to the great traditions and ethical standards of the past. Centuries of progress in the conquest of disease gives us confidence that the individual and not the group should remain the unit in the practice of medicine.

We wish to emphasize once more in closing our accord with the majority of the committee in their recommendations for improvements in public health service and in the scope of medical education. We would especially express our appreciation of the great value of the mass of factual data compiled by the staff and so ably summarized in the Summary Volume.

A. C. Christie.
George E. Follansbee.
M. L. Harris.
Kirby S. Howlett.
A. C. Morgan.
A. M. Schwitalla.
N. B. Van Etten.
Olin West.
Robert Wilson.

(Subsequently Mr. Biemiller submitted the following statement:)

In my testimony I stated that in 1932 the AMA recommended compulsory health insurance.

Senator Donnell took exception to the implications of that remark and pointed out that the AMA now unquestionably opposes compulsory health insurance. I agree with the Senator's contention completely.

I appreciate Senator Donnell's having inserted in the record the AMA's 1932 minority report on the committee on the costs of medical care inasmuch as it together with my statement makes crystal clear the idea I was attempting to convey and which the Senator called into question. That idea can be simply stated and is of great importance. It is briefly this:

In 1932, when there was little organized demand on the part of the people for Federal health insurance, the AMA studied the proposals and decided that it was opposed to insurance in any form. But the AMA logically decided and stated that if we were to have health insurance in this country "the sensible and logical plan would be to adopt the method to which European countries have come through experience; that is, a compulsory plan under governmental control."

No matter how it condemned compulsory health insurance, the AMA, after study, believed it far better than voluntary insurance.

Now that the public demand for health insurance is so strong that even Senator Taft joins Senator Donnell in advocating it, the AMA, with no new studies and under political pressure, suddenly reverses itself and plumps for voluntary insurance under monopolistic medical society control. To me this means that the AMA's advocacy of voluntary plans is insincere. The people have decided that we must have health insurance. The AMA was right when it said that if we must, it should be compulsory health insurance under governmental control.

I thank Senator Donnell for allowing me to clarify this matter for the record.

Senator Donnell. Our next witness is Dr. John P. Peters, secretary for the Committee of Physicians for the improvement of Medical Care. We are glad to have you with us. You appeared on April 23, 1946, before Senators Murray, Ellender, and myself.

Senator Murray. Doctor Peters, I will probably have to leave before you conclude your testimony but I will read it very carefully in this record. I want to apologize for not being able to remain throughout your testimony.

Senator Donnell. Will you please state your full name, address, and the educational institution with which you are connected and the committee which you represent.

Dr Peters. My name is John P. Peters, Jr., and I am a member of Yale University School of Medicine, and that is my address.

Senator Donnell. Now, what is this committee which you represent?

Dr. Peters. If I may be permitted to read the first part of this statement.

STATEMENT OF DR. JOHN P. PETERS, SECRETARY, COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE

Dr. Peters. I appear as the representative of the Committee of Physicians for the Improvement of Medical Care, Inc., of which I am secretary. The committee is a group of physicians, now numbering 40, interested in the promotion of a national health program for the improvement of medical care in this country. Its activities consist chiefly of analyzing national legislative measures, about which they publish statements which are regularly sent to a mailing list of about 1,500, chiefly physicians, who are interested in and sympathetic with the aims of the committee. Copies are also sent upon request to any individuals or organizations that desire them.

Senator Donnell. Who is the present chairman of that committee?

Dr. Peters. Dr. Edward Young, of Boston.

Senator Donnell. Edward Young, of Boston. I want to ask you before I forget, Is your son a member of this organization?

Dr. Peters. No; he is on the mailing list.

Senator Donnell. Is he connected with a hospital?

Dr. Peters. He is in the Army.

Senator Donnell. The complete list of the Committee of Physicians for the Improvement of Medical Care, Inc., appears, does it, on page 989 of the proceeding on S. 1606?

Dr. Peters. There would be one or two changes.

Senator Donnell. With the exception of the changes?

Dr. Peters. If you wish, I will be glad to send you a list.

Senator Donnell. Will you do that?

Dr. Peters. I am sorry I haven't a list here.

Senator Donnell. If you will be kind enough to file it with the clerk of this committee. Proceed, Dr. Peters.

(Subsequently Dr. Peters submitted the following roster:)

Members of the Committee of Physicians for the Improvement of Medical Care, Inc.

August 20, 1947.

Chairman: Dr. Edward L. Young, Boston, Mass.
Honorary chairman: Dr. Russell L. Cecil, New York, N. Y.
Vice chairmen: Dr. George M. Mackenzie, Cooperstown, N. Y.; Dr. Allan M. Butler, Boston, Mass.
Honorary vice chairman: Dr. Channing Frothingham, Boston, Mass.
Secretary and treasurer: Dr. John P. Peters, New Haven, Conn.
Administrative committee: Dr. John S. Lockwood, New York, N. Y.; Dr. Joseph Stokes, Jr., Philadelphia, Pa.

Alving, Alf, Chicago, Ill.
Bernheim, Bertram, Baltimore, Md.
Binger, Carl, New York, N. Y.
Boas, Ernst, New York, N. Y.
Bowen, Byron D., Buffalo, N. Y.
Bradbury, Samuel, Philadelphia, Pa.
Boyd, Julian D., Iowa City, Iowa.
Casamajor, Louis, New York, N. Y.
Clark, Dean A., New York, N. Y.
DeNormandie, Robert L., Boston, Mass.
Faxon, Nathaniel W., Boston, Mass.
Flood, Charles A., New York, N. Y.
Goldblatt, Harry, Los Angeles, Calif.
Jones, T. Duckett, New York, N. Y.
Kerr, William J., San Francisco, Calif.
Lukens, F. D. W., Philadelphia, Pa.
McQuarrie, Irvine, Minneapolis, Minn.
Mackler, Harry, Elizabeth, N. J.
Means, James Howard, Boston, Mass.
Miller, Benjamin F., Chicago, Ill.
Minot, George R., Boston, Mass.
Mott, Fred D., Regina, Saskatchewan, Canada.
Palmer, Walter L., Chicago, Ill.
Richardson, Henry B., New York N. Y.
Robinson, G. Canby, Baltimore, Md.
Seegal, David, Welfare Island, N. Y.
Smith, Clement, Cambridge, Mass.
Smith, Richard M., Boston, Mass.
Whipple, Allen O., New York, N. Y.
Wilson, James L., Ann Arbor, Mich.
Winternitz, M. C., New Haven, Conn.
Wood, Barry, Jr., St. Louis, Mo.

Dr. PETERS. First, I should like to submit for incorporation in the record the two most recent statements of the committee—No. 22, dealing with S. 1320, and No. 23, dealing with S. 545. I have copies of those if you wish. They are attached to the statement I submitted but these are copies of them.

Senator DONNELL. Thank you, Doctor.

Dr. PETERS. They are in the original statement appended thereto. These give in detail the authorized opinions of the committee with respect to these bills. I should like to supplement these with certain remarks, pertinent especially to S. 545.

In the preamble to S. 545 the inadequacies in the present distribution of public health, medical, and dental services are recognized. It is declared that it is the policy of the United States to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status, with the obvious implication that this bill is the instrument intended to implement this declaration. Actually the bill, like the one proposed by Senators Taft, Smith, and Ball in 1946, contents itself with increasing, through grants-in-aid to the States, the amounts available for medical relief. It is proposed that total or partial costs of care for all persons who cannot meet these costs from their own resources shall be paid from the funds provided through these grants. If the size of these grants is compared with any authoritative estimates of incomes and costs of medical care, their inadequacy is at once apparent. Either the program must fall short of providing care to all those in need or it must provide care of inferior quality.

A means test, which such provisions will necessitate, besides being inherently objectionable, is unrealistic. No fixed standards of eligibility can be established for such unpredictable risks as illness and disability. For partial care eligibility would have to be determined during the very course of an illness.

The administrative features of the bill are ill devised. There is no reason to believe that a medical practitioner will be best qualified to direct the numerous and diverse activities of the contemplated health agency. Separation of the medical-care program from public-health services at the Federal level violates the principle that prevention and care should be combined. The provision that five of nine members of the National Medical Care Council must be doctors neglects the fact that modern medical care of high quality requires the cooperative efforts of many professional groups.

More serious is the lack of any positive provision for lay representation. Medical care is meant for patients, not doctors. But, after all, the council is given no specified authority or responsibility with the single exception that it can override the Director's refusal to accept a State plan, and no mandate is placed upon the Director to utilize the services of the council. No minimum standards are established with which a State must comply in order to receive grants. In fact, the Federal administration is positively prohibited from taking any action to safeguard quality of care in State programs, for protection of its people and the public purse.

The utilization of nonprofit insurance agencies as intermediaries violates the principle that tax funds should be expended through public agencies by public officials who are accountable to the taxpayers. Besides, on no actuarial basis can a constantly shifting population be insured for costs of services.

The majority of the people desire access to medical care which the proponents of this bill confess is not available. They wish to receive this care on a self-respecting basis. This bill offers them these services only after they have been reduced to seeking charity through the indignity of a means test. It makes not even a gesture toward the improvement of medical care.

The Committee of Physicians believes that in all respects S. 1320 is superior to S. 545. The former offers a carefully considered comprehensive program to meet the deficiencies in medical care that the proponents of S. 545 admit. It seriously aims to carry out the "policy of the United States to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status," the quotation being from S. 545.

The Committee of Physicians for the Improvement of Medical Care, Inc., strongly opposes the passage of S. 545. It is not conceived in terms that can provide even a foundation for a national health program. It gives no consideration to the quality of medical care or its improvement. It does not facilitate the access of medical care of that part of the population that most needs it. Its administration would be difficult and excessively costly in terms of the benefits obtained.

The Committee of Physicians for the Improvement of Medical Care, Inc., does favor passage of S. 1320 with certain modifications which it has recommended in its statement No. 22 dealing with this bill.

Senator DONNELL. Any questions? Thank you very much for coming.

(Statements Nos. 22 and 23 as submitted by Dr. Peters are as follows:)

STATEMENT NO. 22. DISCUSSION AND RECOMMENDATION OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC., ON THE NATIONAL HEALTH ACT OF 1947, S. 1320, INTRODUCED BY SENATOR MURRAY (FOR HIMSELF, MR. WAGNER, MR. PEPPER, MR. CHAVEZ, MR. TAYLOR, AND MR. MCGRATH), MAY 20, 1947

The present bill follows the precedent of its two last predecessors in separating the medical provisions of the national health program from the social and financial provisions which are required to make the medical provisions effective. The needed social-security legislation is, however, implicit in the terms of the present bill. This follows the general principles of previous bills in establishing a national health program with wide coverage in which health services for self-supporting members of the population will be financed chiefly through compulsory insurance. The bill differs from previous bills in providing for Government contributions. The administrative structure has been radically altered to promote decentralization and local control. Since the Federal health and welfare agencies have been consolidated under a single authority, it has been possible to combine provisions for expansion of public health and maternal and child-welfare programs under a single title, which also contains provisions for expansion of the hospital-construction program.

PURPOSE

The Committee of Physicians for the Improvement of Medical Care, Inc., is heartily in sympathy with the principles expressed in title I and appreciative of the efforts of the authors of the bill to devise legislation that will achieve these purposes. Whatever imperfections the bill may have, the receptive attitude which these legislators have displayed toward constructive criticism, and the sincerity of their attempts to meet these criticisms, cannot be questioned.

COVERAGE

The Committee of Physicians for the Improvement of Medical Care, Inc., from its inception has realized the difficulties of undertaking at once a program to provide health services to all or nearly all the people in the United States with resources and personnel inadequate in numbers, experience, and distribution immediately to furnish these services. On the other hand, it again recognizes that no practical or equitable program for less comprehensive coverage has been found. Experience and experiments are not lacking to aid in the proper direction of such a program. Sufficient latitude is given in the bill to permit further experimentation. In fact, the varied large-scale, long-term experimentation that is required cannot easily be carried out except through the institution of such a comprehensive program which alone can provide the necessary funds. A long time has elapsed since the need for a national health program became evident. This should not be extended indefinitely.

If broad coverage is contemplated, it is inequitable to except from the program small groups or fractions of the population. The Committee of Physicians is, therefore, pleased to note that provision has this time been made for the inclusion of civilian Federal employees. It regrets that the inclusion of employees of State and local governments must be conditioned upon special arrangements by these divisions.

The elimination of a separate program for the needy and the substitution of a simple formula by which the States may, with the help of Federal grants-in-aid, pay premiums for needy persons, thus enabling them to enjoy the benefits of the services to which insured persons are eligible, is a distinct advance. In previous statements (16, 18) the Committee of Physicians for the Improvement of Medical Care, Inc., has advocated this procedure. It will make all members of the population continuously eligible for the same services. Under a dual program a certain number of individuals in the marginal income group would be continually shifting between the two systems of medical care. If States wish to continue to distinguish between needy and employed persons with respect to medical services, they cannot well be denied the privilege, but such a distinction is inappropriate in a national health program as it would be in a system of public education.

FINANCIAL

The present bill recognizes that predictions of costs, especially in a period of shifting prices, are uncertain. It retains the basic premium rate of 3 percent of earnings up to $3,600, but adds provisions for supplemental Government contributions. It is evidently the hope that these may permit the inclusion of dental and home-nursing benefits, but it is subsequently admitted that inadequate funds, facilities, and personnel may delay the realization of this hope. Latitude is wisely given for supplements, the use of which will not be restricted. The amount of these supplements is prudently limited during the developmental years of the program. It is earnestly hoped that the value of the program will be sufficiently impressive to stimulate the public to treat it generously after this preliminary period, or, if need be, to revise these appropriations at an earlier date.

Of great importance to the realization of high quality of services are the provisions that funds must be allocated among the five classes of personal health-service benefits and that sums allocated to one class may not be diverted to pay the costs of another class. This seems to meet an objection of the Committee of Physicians for the Improvement of Medical Care, Inc., to previous bills. It was pointed out in statements 13, 15, 16, and 18 that under agreements with hospitals for complete care of patients, including services of physicians, funds allocated for hospital care and associated services should be distinguished from those allocated for medical services, the latter being reserved for payment of members of the medical staff. Without such specific provisions, institutions might be tempted to compete on a basis that would lead to exploitation and economic debasement of physicians. This, in turn, would lead to depreciation of the quality of medical services. It has been justly pointed out that, since physicians practicing in hospitals utilize the facilities of these institutions, some part of the funds allocated for physicians' services should revert to the hospitals. The general clause enjoining the diversion of funds from one class of health services to another would not exclude such payment for facilities; it would impose upon administrative agencies, institutions, and physicians the obligation to observe the strictest equity in arrangements for such payments. The extension of similar protection to all classes of persons engaged in furnishing medical services is an excellent measure.

ADMINISTRATION

Federal.—The bill, although retaining for the Federal authority the right to establish primary standards and regulations, disperses ultimate administrative functions as far as possible to local agencies, with State agencies as intermediaries. This should have the desirable effect of spreading interest in the program, of arousing local pride and provoking health emulation between communities. It should also promote useful variety of experiment. Against this must be weighted the fact that at the local level selection is often sadly limited and personal interest and factors of personality are prone to assume undue importance. If the complicated administrative structure proposed in this bill is to achieve its purpose, the allocation of responsibility between the authorities at different levels must be planned with great wisdom and will require revision with experience. Fears of overcentralization and bureaucracy must be balanced against dangers of too great dispersion and the multiplication of personnel and overhead costs which this may entail. The discretion which is given to both Federal and State agencies in their functions of establishing standards and regulations offers some protection against these evils and therefore should not be curtailed.

Consolidation of ultimate Executive authority in the hands of a Presidential appointee, the Federal Security Administrator, is in line with our established precedents. It links accountability with responsibility. The recent reorganization and consolidation of health and welfare services under a single head has made it posible to coordinate the parts of the national health program more effectively than before.

The composition of the proposed National Health Insurance Board is open to criticism for several reasons. The accepted formula was apparently devised to allay fears of arbitrary or dictatorial control by a single head, the Surgeon General of the United States Public Health Service. It violates, however, the very principle so carefully preserved in the ultimate authority, the conjunction of accountability and responsibility. These essential properties are dispersed and concealed as they were in the provisions for administration of the Hospital Construction Act to which the Committee of Physicians for the Improvement of Medical Care, Inc., objected. (See statement 19.) In addition, this Board contains two ex officio members who will also serve as the effective administrators or executives of the program, the Surgeon General of the Public Health Service and the Commissioner for Social Security. These two will be charged with the promotion of certain practical objectives. Since these activities are the chief concern of the Board, these ex officio members will be suitors to the body on which they must serve as advisers. Presumably the other three members would be appointed because of their broad knowledge and competence as impartial advisers; there is no assurance that ex officio members, selected for administrative ability, would have these qualities. Nevertheless these ex officio members would be at a great advantage because their duties on the Board would be part of the functions of their offices. On the other hand, they could escape accountability for imperfect conduct of these administrative offices by reason of their concealed positions on the Board. The Committee of Physicians for the Improvement of Medical Care, Inc., is of the opinion that a single appointed administrator (or a professional administrator, the Surgeon General; and a financial administrator, the Commissioner for Social Security), supported by an expert advisory council or councils which cannot be short-circuited nor circumvented will be more efficient and more responsive than the Board proposed in this bill. The functions now assigned to the Board, which appear to be well devised, would in this case devolve upon these administrators, subject to the approval of the Federal Security Administrator.

In this case it might be necessary to provide separate advisory councils for the two heads as previous bills did. The general formula for the composition of the Advisory Council seems sound. To give a majority to representatives of consumer interests is reasonable since this is the larger body for whom the services are intended. The interests of the consumers are not divorced from those of the service groups. Presumably both desire the best possible service. If appointments are made with due consideration of the aims of the program, the service groups should not suffer. Indeed it may be greatly to their advantage to have the support of a large body of lay advocates. If appointees are selected without due appreciation of the aims of the program, it will matter little whom they represent. The effectiveness of the Council under any formula must depend upon the wisdom and integrity of the appointive authority and the alert interest of the professional groups and beneficiaries concerned with the program.

Since similar formulas are used for State and local councils and committees, it will be unnecessary to discuss the composition of these bodies separately.

The Board is instructed to seek the advice of the Council concerning almost every detail of policy or regulatory provision in the bill. It is also compelled in its reports to record the proceedings and recommendations of the Council, so that failure to accept these recommendations will be subject to scrutiny by Congress and the public. Such a procedure is appropriate if the "person" to which the Council exercises its advisory functions is an individual. There is a certain incongruity in a Council advisory to a board. The latter has an advisory function of its own and, in addition, may have minority opinions, for the proper publicity of which no provision appears to have been made. If an administrative board is established it might be more appropriate to implement it with the kinds of expert committees which the Council is empowered to constitute.

State.—The provision that each State prepare an acceptable plan in order to qualify for participation in the program gives reasonable assurance that the general aims of the program will be uniformly observed and that Federal funds will not be misused. The principles governing the character of these plans seem well devised to facilitate over-all administration without stereotyping services. Suitable provision has been made for study and for evolution of these plans. If a State is dilatory in the preparation of a suitable plan, the Federal authority is empowered to put the program into effect in that State pending the preparation of such a plan. Such a provision is essential, since it would be an injustice to deprive the people of the State of the benefits of a program for which they would be paying.

Provisions for the State advisory councils follow those of the Federal administration.

Local.—Among the conditions imposed upon the State plans is the establishment throughout the State of local health-service areas which will serve as the ultimate administrative units of the plan. Those areas are permitted to elect either one of two types of agencies: (1) An administrative committee with an executive officer or (2) an appointed administrative officer with an advisory committee. The first type of agency is open to the same objection advanced against the National Health Insurance Board in the Federal structure. Responsibility and accountability will be dispersed and concealed. Whereas at the Federal level a board of only five members is proposed, these local committees are to be composed of from 8 to 16 members. A body of this size is ill-suited to administrative functions. Its members will presumably be unpaid, serving on a part-time basis. The committee will of necessity be obliged to serve chiefly in an advisory and consultatory capacity. The executive officer will be forced to perform the actual administrative functions, which will frequently be of such urgent character that they cannot wait for the action of so clumsy a committee. If, by chance, the members of the committee are negligent or preoccupied with their more personal interests, the executive officer will be altogether unrestrained. In point of fact, the two types of agencies are likely to differ in only one respect—the administrative officer can be held accountable for his errors the executive officer can escape accountability. In both instances the persons responsible for administration are to be appointed by the State agency, which may be expected to exercise no less judgment in the selection of an administrative officer than in the selection of members of an administrative committee. The Committee of Physicians for the Improvement of Medical Care, therefore, favors retaining only one type of agency—an administrative officer with an advisory committee. The functions prescribed for these agencies appear to be satisfactory.

Local professional committees seem superfluous. The administrative and advisory committees will contain representatives of the professions which furnish services. In addition, the interests of professional personnel will be protected by their professional organizations. Local health areas can hardly be expected to supply personnel of satisfactory quality for both administrative and professional committees. It would seem better to empower the administrative committees and advisory councils to appoint ad hoc committees of various types when necessary.

BENEFITS

In most respects the health-service benefits proposed are the same as those offered by previous bills. They are truly comprehensive. One addition has been made—unusually expensive drugs, under regulations established by the board, are included. The most serious evils of the restriction upon drugs are removed by the present proposal, which will also give the board an opportunity, by experiment, to find formulas that will permit the inclusion of an increasing number of drugs.

Objectionable limitations upon general medical services have been happily eliminated from this bill. The temporary limitations placed upon dental, home-nursing, and auxiliary services are little more than a recognition of the fact that sufficient personnel and facilities will not be immediately available with which to provide these services.

Free choice with respect to all types of services is guaranteed to beneficiaries. Access to services other than those of general practitioners, including services of specialists, however, must be secured by reference through a practitioner or an administrative medical officer. Such a provision is essential to prevent self-diagnosis and the unnecessary use of more costly facilities and personnel. Protection against delay in securing needed care is assured by exception of emergencies.

PARTICIPATION OF PERSONS IN SERVICE

Any person can furnish, under the terms of the bill, services which he is legally qualified, under State laws, to furnish, provided he agrees to participate in the program and to abide by the regulations established for the conduct of the program. Where there are no State regulations, the Board is empowered to establish standards and regulations for qualification. Such a provision is not only desirable but essential as a safeguard against gross inequities in the quality of services in the various States and the expenditure of Federal funds or inferior services in States that maintain no standards.

Groups of various kinds, including hospitals or hospitals and their staffs, will be utilized. In addition to these operative groups, voluntary health service insurance agencies, whether or not they enter into agreements with the State agency on their own behalf, are also permitted to act as agents for individuals or persons for rendering personal health services under the program. The individuals or persons who actually furnish the services must, however, have entered into agreements with the State agency. Private insurance agencies are not required for a compulsory system with almost universal coverage. Such intermediaries between the Government and the beneficiaries can only increase administrative costs. There is a proper place for these agencies in the provision of extra services.

METHODS OF PAYMENTS FOR SERVICES

These are in most respects the same as those in previous bills. The majority of general practitioners in a local health service area may elect the method of payment for practitioners' services that shall prevail in that area—fee-for-service, per capita, or salary. Opportunity shall be given, however, to members of the minority to practice under the methods of payment they may prefer. These privileges, in previous bills, were unconditional. In the present bill they need be granted only "when it is found that such alternative method contributes to carrying out the provisions of section 235," which declares the principles of the program, or otherwise promotes efficiency and economy. The Committee of Physicians for the Improvement of Medical Care must again express its opposition to the inclusion of the fee-for-service method of payment unless they are included in competition with other methods of payment. In previous statements it was admitted that if, because of the pressure of organized medicine and the uninformed state of public opinion, it could not be excluded, a compromise that established competition between individual practitioners, groups, and hospital organizations on fee-for-service or other bases of payments could be accepted, because it would establish competition in which the relative virtues of various methods of payment could be tested. The proviso in the present bill removes assurance of such completition. The terms in the last bill are to be preferred. The word "contributes" in the present bill is peculiarly unfortunate because it is too broad and indefinite, a subject of opinion. If the previous formula cannot be restored, the Committee of Physicians for the Improvement of Medical Care at least recommends that the words "contributes to carrying out" be deleted and that the words "is consistent with" be substituted for them.

In provisions for payment to specialists the words "or other basis" convey no meaning. If they are retained, all other specifications may as well be omitted. They are used with respect to no other class of service.

In a period of economic flux it is realistic to leave unspecified the actual amounts of payments to hospitals. The bill provides "for payment on the basis of the reasonable costs of hospitalization benefits." It would be advisable to substitute for the words "reasonable costs" the phrase "costs reimbursable upon the basis of accepted cost-accounting systems." Obviously there must be standards for comparison on which maximum rates will have to be established.

The provision for prorating among practitioners furnishing services on a per capita basis payments with respect to unallocated individuals seems a happy solution for a highly controversial problem.

The special provisions for rural areas offer an experimental approach to the solution of the problem of distribution of physicians and means for furnishing service in thinly settled areas.

AMOUNT OF PAYMENT

The Committee of Physicians for the Improvement of Medical Care believes that the principles on which rates are to be fixed have been thoughtfully prescribed with careful attention to equity, economy, and efficiency. Success of the program will ultimately depend upon the value that the public sets upon its health. Especially important is the provision that equivalent services must be equally rewarded under all methods of payment. Only if this principle is observed will the best method be ascertained through experiment and competition. The provision against overloading of physicians is commendable in principle, but discretion will be required in its administration lest it be used to expand the clientele of the inferior and incompetent physicians of an area at the expense of the superior and competent.

The provision for equalization of payments under agreements with groups and other organizations is also gratifying. It should be specified that this refers not only to operating groups but also to intermediaries such as private voluntary insurance agencies, to administrative costs as well as costs of services. Objections to the inclusion of such intermediaries would be removed if their participation were contingent upon proof that they did not add to the expenses of the program nor detract from the rewards of those who actually furnish services.

PROFESSIONAL RIGHTS AND RESPONSIBILITIES

This section, which affirms existing laws and usages, is satisfactory.

CONFIDENTIAL INFORMATION; NONDISCRIMINATION

The Committee of Physicians for the Improvement of Medical Care heartily approves the intent of this section.

COMPLAINTS, HEARINGS, ETC.

Adequate protection has been given in these sections for judicial prevention of abuses and protection of individuals against injustice.

GRANTS-IN-AID FOR MEDICAL RESEARCH AND EDUCATION

Again, the Committee of Physicians for the Improvement of Medical Care endorses the consideration given research and education, so fundamental to the advancement of the quality of medical care. It feels that medical care can be best advanced if aid for investigation and education is distributed with regard only for the ability of the beneficiaries to use these opportunities to the greatest advantage. It disapproves any priority to special groups, although it recognizes that they may have special deserts. Every effort should be made by other means to meet the needs of veterans. This program is projected not for the exigencies of the moment, but for the improvement of the medicine of the future.

TITLE III. DEVELOPMENT AND EXPANSION OF HEALTH SERVICES

This title has the same objectives as the programs for expansion of public health and maternal and child welfare services in previous bills. It is to be financed by grants-in-aid to the States. Because of the consolidation of Federal health and welfare services it has been possible to plan a coordinated program. In certain respects the proposals of the present bill differ from those of previous bills. Administration is to be delegated to the States which must prepare plans in order to qualify for grants. One of the main objectives of the bill is to establish throughout the United States efficient full-time public-health services. This is an extremely desirable object that has the full support of the Committee of Physicians for the Improvement of Medical Care. The extension and expansion of the programs for the elimination of tuberculosis and venereal diseases have already been endorsed by the committee. The establishment and maintenance of adequate health services for the early detection, prevention, and treatment of mental disorders, cancer, heart and degenerative diseases, and dental disorders, though equally worthy, will not be altogether practicable until more is learned of the origin, nature, and treatment of these conditions. Better means for the care of the aged and chronically ill, another objective, are sadly needed. Without provisions for the training of personnel, which are included, the program could not be carried out.

CONSTRUCTION OF HEALTH FACILITIES

The expansion of the hospital construction program proposed in part B of this title also receives the support of the Committee of Physicians for the Improvement of Medical Care. It has already become apparent that the provisions of the original act will not meet the requirements of the Nation. Without adequate facilities, the people cannot realize the full benefits of the national health program.

CONCLUSION

The Committee of Physicians for the Improvement of Medical Care, Inc., approves the passage of this bill with the modifications it has suggested.

COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT
OF MEDICAL CARE, INC.,
JOHN P. PETERS, M. D., *Secretary.*

STATEMENT NO. 23. DISCUSSION AND RECOMMENDATION OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC., ON THE NATIONAL HEALTH ACT OF 1947, S. 545, INTRODUCED BY SENATORS TAFT, SMITH, BALL, AND DONNELL, FEBRUARY 10, 1947

GENERAL PURPOSES

As expressed in the bill its aims seem laudable enough, the reasons for them plausible. They must, however, be examined in the light of fact and the effectiveness of the provisions in the act.

NATIONAL HEALTH AGENCY

A year ago there was just cause for complaint about the dispersion of health and medical services among Federal agencies. This was, however, largely removed by President Truman's organization plan I, which coordinated these services within the Federal Security Agency. No obvious advantages can accrue from scrapping existing agencies which have been built into efficient functioning bodies. Such a movement suggests a merely partisan spirit. If further emphasis on coordination of health and medical functions is desired, S. 140 seems more wisely devised than is S. 545.

The provision that the Administrator must have practiced medicine will not assure the appointment of the person best equipped to direct the numerous and diverse activities of the contemplated agency. In fact, the peculiarly individualistic pursuit of medical practice may not be the best background for an administrative career. Administrators of the medical-and dental-care services must also be selected from the ranks of practitioners, with the additional restriction that they must have had 5 and 10 years, respectively, of active practice. Such limitations ignore certain fundamental facts: (1) That these services are intended for and will be supported by the public, not practitioners; (2) that they will require participation of members of other professional groups; (3) that practice is not the only ingredient of medicine; education and investigation cannot be neglected at any level. Physicians and other professional groups who will furnish services have their own proper places in administration at the operative level. They should rightly have representation at all levels, but this does not imply that they must have a dominant influence.

There is already established in the Federal Government an agency, the United States Public Health Service, which has had broad experience in the administration of medical care for the needy. The allocation of the programs now proposed to two newly constituted agencies is strangely at variance with the professed purposes of the bill and can only lead to duplication and confusion.

AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Compared with the proposals of S. 1320, the amendments embodied in S. 545 are unimaginative and inadequate. The appropriation of $10,000,000 for the control and prevention of cancer selects only one special service with a strong sentimental appeal. The most pressing need is the extension and strengthening of public-health services throughout the country, especially the establishment of coordinate State and local health agencies staffed by full-time professional personnel. Without these instruments special services, whether for cancer or any other purpose, cannot be made thoroughly effective.

GENERAL MEDICAL SERVICE FOR FAMILIES AND INDIVIDUALS WITH LOW INCOME

This is the measure mentioned in the preamble under the phrase "for other purposes" and intended to fulfill the declaration that it is the "policy of the United States * * * to make available medical, hospital, dental, and public health services to every individual * * *." The bill, like the one proposed by Senators Taft, Smith, and Ball in 1946, merely increases through grants-in-aid to the States the amounts available for medical relief. All the objections that were raised to the former measure (see statement 21) are equally applicable to this.

FINANCIAL

It is declared that total or partial costs of care for all persons who cannot meet these costs from their own resources shall be paid from the funds provided through these grants. If this is the real intent, authoritative estimates of incomes and costs of care indicate that the sums available will be inadequate to provide for the needy services of desirable quality.

CONDITIONS FOR RECEIPT OF GRANTS

If the program is to be financed by grants-in-aid to the States and is to be administered entirely at the State level, the elaboration of acceptable plans by the States is certainly desirable. The qualifications for acceptability of these plans are well conceived in certain respects—organization under a single State agency with advisory councils, an inventory of existing facilities, and assurance of the financial responsibility of the State and prohibition of discriminatory practices.

Provisions 3 and 4, requiring that the State present evidence that it can within 5 years provide hospital services, surgical services, and medical services for all persons unable to pay the whole cost of such services, actually have little potential value since the Federal agency is given no power to safeguard the quality of service or the criteria of eligibility. In fact, such rights seem to be specifically denied to the Federal authority by the clause stating that neither the Administrator nor any Federal employee has the "right to exercise any supervision or control over the administration, personnel, maintenance, or operation of the health services with respect to which funds have been or may be expended under this title." This violates the sound principle that the Federal agencies dispensing public moneys should be held responsible to the people for the quality of what is purchased. To grant to the Federal authority no power to establish minimal standards of quality for personnel, facilities, and operation is flaunting all experience. Such qualifications of merit have proved invaluable instruments in the removal of local political influences and the elevation of standards of operation in State and local public health services in this country. The possession of such regulatory powers by the Federal agency will not restrict freedom of experimentation in the States. It will only insure that this experimentation be conducted on a decent plane.

Experience has demonstrated that periodic physical examinations for school children are of little value unless provision is made for remedial therapy.

ADMINISTRATION

The director of medical and hospital care services, whose appointment has been discussed above is to have a national medical care council. Including the director as chairman, five of the nine members of this council must be doctors. The need of representation of the lay public at the Federal level is not even mentioned. If auxiliary professions are to be represented there will be little or no room for the public. In its structure the Federal administration seems to follow the principle of the national health bills that have been attacked by the American Medical Association as establishing a dictatorship. Apparently such an administrative structure is acceptable to opponents of S. 1320 so long as the power is centered in the hands of practitioners. One signal feature distinguishes the administrative structure of this bill from that of S. 1320. In the latter it is specified that the administrator must submit all matters of policy to the council for an opinion and must publish these opinions. He is, therefore, placed under compulsion and public scrutiny to utilize the council. In S. 545 no such assurance is given. In only one respect, indeed, does the council have any specified authority: It can override the director's refusal to accept a State plan and to certify the corresponding grant.

NATURE OF SERVICES AND COVERAGE

Each State is guaranteed complete freedom to devise the methods by which the services are to be provided. This freedom is not confined to operative procedures, but extends to administrative and financial features as well. The States are permitted to utilize nonprofit insurance agencies. This is clearly in violation of the long-established principle that tax funds should be expended through public agencies by public officials who represent and are accountable to the taxpayers. In this instance such responsibility is twice removed because the Federal funds are delegated unconditionally to the States by which they may be dispensed through these private agencies. Such a device will only propagate the worst type of political contrivance; it will permit the use of State and Federal funds to subsidize poorly organized and operated insurance programs. The interpolation of intermediary agencies between the State and those who provide the services cannot fail to multiply expense, thus tapping off some of the funds intended to meet the costs of these services.

Of far more importance than these particular features of the bill is the general nature of the provisions for medical-care services. In the discussion of these the committee can do no more than repeat in abstract the opinion it expressed in 1946 about the national health bill presented on May 3 of that year by Senators Taft, Smith, and Ball. Again a comparison must be drawn between the present bill and S. 1320 presented by Senators Murray, Wagner, Pepper, Chavez, Taylor, and McGrath. The latter actually makes provisions to do what S. 545 merely professes: "To make available medical, hospital, dental, and public health services to every individual regardless of race or economic status." Such an ambition is not likely to be realized by the mere passage of enabling legislation, but its realization may be sensibly accelerated by well-considered legislation devised with this object in view. The present bill does not appear to be conceived with any such objectives. It follows the antique formula of relief bills adapted to emergency correction of economic errors, not the constructive pattern appropriate to the prevention of such evils. It makes no gesture to improve or even protect the quality of medical care.

The program for medical care for persons and families with low income rests upon the imposition in each State of a means test. Such a test is inherently offensive to democracy. It becomes particularly objectionable when it is applied specifically to a service linked with such an uncertain risk as illness or disability. The proposals of S. 545 are unrealistic. If they are to be literally interpreted eligibility for aid will be quite unpredictable, because the costs of illness are not, like those for the other necessities of life, fixed or proportioned to general price fluctuations. Even the most conservative authorities admit that the costs of catastrophic or chronic illness are within the means of only a small fraction of the population. The remainder will be shifting in and out of the eligible class continuously. Such change of status, moreover, will be necessitated in the very course of illness; this will create insurmountable difficulties. It is beyond reason to hope that all who are not unconditionally eligible will secure protection through private insurance. If such a consummation were expected or desired, the proponents of this bill would logically have turned to compulsory insurance. Under the provisions of S. 545, however, the uninsured who, through illness or disability, are reduced to poverty, will become a charge upon those taxpayers who are insured. This will impose upon the latter a double penalty and will tend to discourage voluntary insurance. The undesirability of utilizing nonprofit insurance agencies as intermediaries in the operation of State plans was mentioned above. In point of fact this would seem not only undesirable, but impracticable because there is no actuarial base on which a constantly shifting population can be insured for costs of service, especially when these include partial costs.

The popular demand for a change in the present system of medical care arises from the desire of the majority of our population to be given access to better medical care and be allowed to enjoy in fuller measure the benefits of modern advances. This bill does nothing to meet these demands. It gives no consideration at all to the quality of medical care or its improvement. It offers nothing but the promise of access to charity services of uncertain quality through the indignity of a means test, if, through illness or disability, they may suffer economic losses. The outstanding fact that there is a large proportion of the population, in other respects self-supporting, that has not a large enough economic margin to be expected to pay for the costs of its own medical care, even through voluntary insurance, has been completely neglected. Unless even the most conservative estimates are faulty the appropriations proposed in this bill cannot pretend to provide for this large group, especially when part of these moneys must be diverted to pay for periodic examination of school children. S. 545 appears to have been devised not to provide more and better medicine for the people, but to relieve physicians of part of the burden of charitable services. There may be doubt whether it will achieve even this purpose; it may only expand and cheapen these services.

DENTAL-HEALTH SERVICES FOR SCHOOL CHILDREN AND FAMILIES AND INDIVIDUALS WITH LOW INCOME

This program is so similar to that for medical care that it requires little separate discussion. It is equally objectionable. Considering the wide scope of services proposed in this title, including examinations and care for school children, the appropriations seem altogether inadequate.

In one respect the title differs from its medical counterpart. It includes special appropriations for research, a large part of which are to be spent upon the construction of a building and the support of investigation to be conducted in this building. In relation to previous bills which contained similar proposals the Committee of Physicians for the Improvement of Medical Care pointed out (Statement 21) that a building in the District of Columbia is not the primary requisite of a research program and that the segregation of the various components of medicine is not the soundest way to advance medical knowledge.

GENERAL CONCLUSIONS

The Committee of Physicians for the Improvement of Medical Care can do no better than reiterate what it said of the National Health Act of 1946, introduced by Senators Taft, Smith, and Ball on May 30 of that year. "The bill fails not only to provide a national health program, but also to establish a foundation upon which such a program can be built. It is not conceived in terms that promise to improve the quality of medical care. It does not facilitate the access to this commodity of that part of the population most in need of it. Its administration would be difficult and excessively costly in terms of the benefits to be obtained. It is an undemocratic measure full of features that will foster extravagance, waste and abuses."

It is the studied opinion of this committee that S. 545 is an unsatisfactory measure. It therefore strongly opposes the passage of this bill.

Committee of Physicians for the Improvement of Medical Care, Inc.,
John P. Peters, M. D., *Secretary.*

Senator Donnell. Is Mr. McMichael here?

Reverend Smith. I represent the same organization.

Senator Donnell. Will you please state your full name for the record and tell us what organization you represent?

Reverend Smith. I am the Reverend Alson J. Smith, bulletin editor of the Methodist Federation for Social Action, which was organized in 1907. At the present time 17 bishops and 4,000 ministers and laymen of the Methodist Church are affiliated with our organization. Our headquarters are at 150 Fifth Avenue.

Senator Donnell. Will you proceed with your statement?

STATEMENT OF REV. ALSON J. SMITH, BULLETIN EDITOR, METHODIST FEDERATION FOR SOCIAL ACTION

Reverend SMITH. Mr. Chairman, honorable committee members, I am profoundly grateful for this opportunity to present to this committee the official position of the Methodist Federation for Social Action on this urgently needed legislation, S. 1606, called the national health bill. We as a group of Methodist ministers and laymen heartily endorse the principle of health insurance as embodied in S. 1320 and are opposed to the substitution of the Taft bill, S. 545.

The Methodist Federation for Social Action is a fellowship of Christians who seek to apply the principles of our Lord to every area of human relationship, and to do His will. We have as our national president, Bishop Lewis O. Hartman, who is bishop of the Methodist Church, the Boston area. Bishop James C. Baker, of California, and Bishop G. Bromley Oxnam, of New York, are vice presidents. The recording secretary is Miss Thelma Stevens, director of Christian social relations of the official women's division for Christian service. The treasurer is Rev. Dr. Gilbert Q. LeSourd, who is also treasurer of the Missionary Education Movement.

It is my humble privilege to edit the Social Questions Bulletin, which is the periodical of the Methodist Federation for Social Action. In this capacity I work closely with the executive secretary, Rev. Jack McMichael, and participate with him in helping build that brotherly world which is the kingdom of heaven. Our federation is devoted to education and social action in harmony with the high ethics of Jesus and to carry forward His work in our day. The concern of Christ and His church for human welfare prompted the formation of this organization in 1907 and its growth, until today, not only within the Methodist Church but in most denominations, there are hundreds, even thousands, who earnestly pray and work for the application of Christianity to all areas of life as expressed in the social creed of the churches.

In the preface to the Methodist Social Creed, the 1944 Discipline adopted officially for all Methodism, states:

> The interest of the Methodist Church in social welfare springs from the labors of John Wesley, who ministered to the physical, intellectual, and social needs of the people to whom he preached the gospel of personal redemption (par. 2010).

John Wesley, the founder of Methodism, was so deeply moved at the illness, disease, and suffering of people that he spent much time in the study of health, wrote books and pamphlets on the cure of illness, and so forth, and established a service that might be called the early or simple dispensary for all in need of health service.

In line with this spirit, and of course in obedience to the precepts of Christ on "healing the sick," the church long ago set up hospitals for the service of man's health. In passing, let it be emphasized that such hospitals are greatly in need of public funds for the ministry to those many needy who are not church members. In regard to the need for national health legislation, one section of the officially adopted social creed is pertinent.

> We oppose all forms of social, economic, and moral waste (No. 4).

Certainly it is obvious that illness is a waste when medical advice or treatment might have prevented it. The appalling loss in employment due to illness is not only an economic waste; it is the theft of some portion of a man's precious life span. It robs society of his potential contribution, in service of all kinds. It affects all volunteer services and all programs for educating, inspiring, and helping mankind.

I would like to refer again to something that Mr. Henderson said. The Selective Service Act in its enforcement showed that 40 percent of all draftees were physically unfit for service in the Army.

In its last annual meeting, the Nation-wide Methodist Federation for Social Action adopted officially a resolution which approved unanimously national health insurance. Our organization is enthusiastically and prayerfully in full and hearty endorsement of the bill entitled "National Health Insurance and Public Health Act of 1947," S. 1320.

We believe that it is a moral and religious necessity. It is an overdue effort to ameliorate the tragic disparity of available health services in this Nation. For while some areas and groups can secure dental and medical examinations and care, yet multitudes of our fellows are denied those fundamentals. Studies by various experts have provided the facts. For instance, one report published in 1939 by the American Medical Association says that people with incomes under $3,000 a year are not able to pay their full medical costs.

Knowing that in the year 1945 about approximately 69 percent of the people belonged to families with incomes under $3,000, it is a terrible human need, and tragic health problem thus presented. The 69 percent of our folk who are unable to pay full medical costs must find some self-respecting form of insurance against illness and other medical emergencies. They ought not to be made the object of charities.

But the question is not only one of the ability to pay; it is also the ability to get medical, dental, and hospital service. There is no better way to do that, than by a form of insurance which provides protection for the unexpected and unpredicted ailment, injury, or disease.

The Federal Government is the only agency in a position to provide the impetus for such a constructive program. Diversity of financial standing among the States works a hardship on some. Thus a Federal program helps to equalize the burden and places the responsibility upon all. Health is an interstate concern. A disease will not stop at a State boundary. In a united country there can be no quarantine of ill health. It affects all, not only in wartime by reducing war manpower, but in peacetime by the waste of human potential and the tragedy of unnecessary illness and death.

The close proximity of nations due to modern transportation has high-lighted the need for world health. Smallpox in Karachi may land in LaGuardia Airport in a matter of hours. Suffering not only spreads, but the unrest and grief in one part of our human family disturbs everyone sooner or later. It has been said that a nation cannot exist half-well and half-diseased. Nor can it be prosperous and happy if its lawmakers ignore its health.

Ministers are close to human need, and as one of Methodism's 40,000 pastors I can give heart-rending evidence of the failure of our present medical service. In large cities where I have served fairly good service is available to the poor who will accept charity with its casual indifference to human dignity. The mother who delays the trip to the clinic for her needy child may hope for improved income so that she can buy medical service. Or the middle-income family that takes a fatal risk in avoiding the doctor bill and lets a child die. There is the adult whose income is just enough to get by on, but refuses necessary examinations until some ailment is too far advanced to check. Lives are shortened, lives are lost because of the high cost of medical service. Ministers trying to comfort the bereaved think of the words, "Woe unto him that causeth one of these little ones to perish." Too many deaths are not the will of God but due to the blindness of men.

I think I can illustrate that, Senator. When I was a young minister out in Montana about 12 years ago, a boy in the community there came down with pneumonia. Now, there was only one doctor in that community. He was the only doctor in the county and the county was as large as the State of Rhode Island. The nearest hospital was 85 miles away. The one doctor advised the boy's parents to have him sent immediately to the hospital, which was at Missoula, Mont. But the parents, realizing that this was an expensive proposition if they paid the full cost, demurred and did not want to send the boy to the hospital. I talked to the family and said that I thought that I could arrange for the boy to go to the hospital without costing them anything. The father of the family immediately took exception to that and said they were not the recipients of charity. He refused to let the boy go to the hospital on that basis and the boy later died.

I had another experience when I was a pastor in Brooklyn. A family there—a woman who needed an operation very badly. I told her that if she could not finance the operation, I would see that she was taken care of at our Methodist Hospital in Brooklyn and it would not cost her a cent. Again, she refused the operation on that basis and said they preferred to wait until the family could finance the operation in the regular way. As far as I know she still has not had the operation. People have a certain pride and certain human dignity that prohibits their accepting that kind of treatment, even though it might mean very serious illness or sometimes death.

May I briefly add a word of opposition to the bill S. 545. The dire need of the poor for health service will not be adequately met by the Taft bill. Nor should they be subject to the humiliation of investigation nor the degradation of a needs test.

As "life" insurance is made available to all, and in some States through savings banks, so and even more cheaply, should health insurance be accessible to all. Or, in another analogy, the need of all the Nation for services to the healthy body is matched by our great educational service to the healthy mind. Why is health of less consequence and value to Government than is education?

To sum up, I would certainly not say, as Mr. Henderson did, that this bill was a political sop. But we believe it is inferior to the other bill, S. 1320 but it certainly is better than no bill at all.

Senator DONNELL. You are speaking of S. 545?

Reverend SMITH. No. To sum up our preference to the other bill, we would say that this bill is not comprehensive enough and does not put enough emphasis on present medicine. It is charity and does provide a means test. The money, $400,000,000, half of which is to be provided by the States, does not provide enough funds to follow the program as outlined in this bill, S. 545. Those are our objections, Senator, to S. 545 and we hope the other bill will be passed. We believe that that bill is better than no bill at all.

Senator Donnell. Do you care to inquire?

Senator Pepper. I certainly am glad to see Reverend Smith this morning, putting so much emphasis upon the Christian aspect of how we can provide adequate medical care in the best way we may hit upon to all the people of the country. It has been my view for a long time that any program must strive for adequacy. If anybody thinks the best way to do it is for the Government to put up all the money, why that is one method of arriving at it. If somebody thinks, as I do, that the best way to do it is to derive most of the funds from an insurance program, that is another method. I think so far it is the best method that has been suggested. I have the same criticism of the Taft bill that Mr. Smith has, that it doesn't have an operative adequacy. At least the Murray bill does have the advantage of striving for adequacy. As I understand, that is about the point of the views you present?

Reverend Smith. That is right.

Senator Donnell. Thank you very much, sir. We appreciate your coming this morning.

We will now hear from Mr. Joseph P. Anderson of the American Association of Social Workers.

Will you please state your name and your address and for what organization you appear.

STATEMENT OF JOSEPH P. ANDERSON, EXECUTIVE SECRETARY, AMERICAN ASSOCIATION OF SOCIAL WORKERS

Mr. Anderson. I am Joseph P. Anderson, executive secretary of the American Association of Social Workers. Our headquarters are in New York City at 130 East Twenty-first Street. I will read the first paragraph from the statement which I have submitted.

The American Association of Social Workers is an organization of professional workers in the field of social work. It was founded 26 years ago and includes in its membership approximately 11.500 practicing social workers. These members are employed in both public and volunteer agencies and are located in all sections of the United States and its territories. The Association has approximately 100 local chapters, which are located in practically every State of the union. As a professional group we believe that we have an obligation to make available to persons responsible for formulating broad policy on social welfare matters the knowledge which we have gained from our experience and education and we welcome an opportunity to present our views on the legislative proposals embodied in Senate bills 545 and 1320.

Senator Donnell. Mr. Anderson, may I interrupt? S. 545 was presented in the Senate on February 10, 1947 and S. 1320 on May 20, 1947. Has your organization had any meetings since either or both of those two bills were introduced?

Mr. Anderson. I would like to say, Senator, that we operate on the principle of developing a statement of principles as a platform statement which deals with a variety of public social programs. We consider health an important one of those. We have been studying the principles on which we believe a sound health program should be based for the past 10 years. We usually assign to a committee the job of working on a particular subject. That committee then prepares a preliminary report which is submitted to a National board of 21, who are elected by the entire membership. This board meets three times a year. After the Board agrees on a statement which embodies principles, that is then submitted to our hundred chapters for discussion, and then once each year these chapters send a representative, one for every 100 members, to an annual delegate conference, at which time there is discussion and then action is taken on a statement of principles.

Frequently, we supplement this statement of principles by taking action at a delegate conference through the form of a resolution. The most recent action on health was taken at a meeting in Buffalo in May 1946 when 72 of our chapters of 100 were represented, at which time we endorsed the principles, the purpose of the application of the then Wagner-Murray-Dingell bill. We have not taken specific action on S. 545 or S. 1320 but I am empowered to present the point of view of our association on legislation as it comes in view of the statement of this principle which we adopted.

Senator DONNELL. Mr. Anderson, your association has not had a meeting, that is, of its delegates since S. 545 or S. 1320 were introduced?

Mr. ANDERSON. There has been a meeting of delegates in San Francisco in April.

Senator DONNELL. Of this year?

Mr. ANDERSON. That is right.

Senator DONNELL. That was before S. 1320 was introduced. Did that meeting in San Francisco in April of this year pass any resolutions or make any official remarks with respect to health?

Mr. ANDERSON. None related to health because the action was taken at the last delegate conference.

Senator DONNELL. In May 1946 at Buffalo at which time your organization went on record in favor of S. 1606?

Mr. ANDERSON. I can send you a copy of the resolution if you would like.

Senator DONNELL. Send it to the clerk of this committee.

Mr. ANDERSON. It stated our position on the basis of principles and philosophy and we supported S. 1606 but felt there were certain amendments or certain sections that ought to be amended.

Senator DONNELL. Will you send to the clerk a copy of that 1946 resolution?

Mr. ANDERSON. Yes.

(Subsequently Mr. Anderson submitted the following resolution:)

RESOLUTION OF THE AMERICAN ASSOCIATION OF SOCIAL WORKERS, NEW YORK, N. Y., ADOPTED BY THE 1946 DELEGATE CONFERENCE, MAY 17, 18, 19, 1946

Whereas the American Association of Social Workers has a deep concern for the health of the Nation and believes that a program of health must provide continuity and integration of health and social services, including preventive, diagnostic, treatment and convalescent care, and

Whereas the American Association of Social Workers believes that the Federal Government should be the guarantor of adequate public health and medical care services; be it—

Resolved, That the American Association of Social Workers endorse the general purposes, principles, and philosophy of the proposed National Health Act, S. 1606, and urge its enactment with such amendments as will serve to extend and strengthen the grant-in-aid and insurance benefits features of the bill; be it further

Resolved, That association chapters and chapter members be urged to communicate to their Congressmen their views regarding the desirability of immediate favorable action on the bill since it is at present being considered in hearings before the Senate Committee on Labor and Education.

Senator DONNELL. You spoke about being embodied to present this here to this committee. Have any principles been passed on S. 545 or S. 1320?

Mr. ANDERSON. We have had a committee——

Senator DONNELL. Let me just get an answer. Has this committee passed on S. 545 and S. 1320?

Mr. ANDERSON. I would like to say that the committee has reviewed S. 545 and S. 1320.

Senator DONNELL. How large a committee was that?

Mr. ANDERSON. That committee is composed of about 18 persons.

Senator DONNELL. Are they from all over the United States?

Mr. ANDERSON. Yes.

Senator DONNELL. They have read through these two bills?

Mr. ANDERSON. That is right.

Senator DONNELL. Have they made any official presentation with regard to these two bills?

Mr. ANDERSON. There has been no motion.

Senator DONNELL. Respecting the board of 21 to which that committee refers its expressions, has that board of 21 made any expression with respect to either S. 545 or S. 1320?

Mr. ANDERSON. No formal action.

Senator DONNELL. Then, the hundred chapters to which the action of the board of 21 is ordinarily referred, have those passed on either S. 545 or S. 1320?

Mr. ANDERSON. Some of them may have made individually. I am not aware of that, whether they have.

Senator DONNELL. You don't know of any that have?

Mr. ANDERSON. No.

Senator DONNELL. Very well—proceed.

Mr. ANDERSON. In summarizing the testimony I would like to say that we are the group, that if S. 545 were passed, would have the job, or at least a good many of us would be called upon to help with this job of investigation to determine persons who have insufficient income to pay.

Senator DONNELL. What is that statement again? I didn't get it.

Mr. ANDERSON. Well, in other programs where there has been a need to determine eligible persons having the kind of knowledge and skill that social workers have, we are usually called upon to help to get that job done.

Senator DONNELL. Who is called upon?

Mr. ANDERSON. Persons who have sick work knowledge and skill—social workers.

Senator DONNELL. You mean—I don't get your statement. Just make that more concrete, will you, please? You are talking about what would be done under S. 545?

Mr. ANDERSON. That is correct.

Senator DONNELL. What is it you say would be done?

Mr. ANDERSON. Maybe I ought to read the statement.

The experience of social workers has amply demonstrated the interdependence of the social and physical aspects of the individual well-being. For this reason the American Association of Social Workers believes that a national health program is an essential and integral part of a broad program of public social services. It believes further that not only health and medical services but social services are essential to the maintenance of health, prevention and treatment of illness and provision of medical care. We also believe that participation by the Federal Government in the development and financing of a National health program is necessary to guarantee adequate and coordinated public health and medical care services and in order that such services should be provided for all people in the Nation as a matter of right, regardless of race, creed, residence and income status.

In view of this position we were very pleased to note the statement of policy in S. 545, section 2 (c), which states "that it is the policy of the United States to aid the States through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status." A review of the other provisions of S. 545, and particularly those in section 712, 4 (a) brings us to the conclusion, however, that this objective cannot be achieved through this bill and therefore we wish to express our opposition to it.

I would like to speak particularly about the provisions of the bill as outlined in section 712.

Senator DONNELL. Mr. Anderson, all this expression of opinion here you say "brings us to the conclusion," and so forth. You mean it brings you to the conclusion?

Mr. ANDERSON. This conclusion is reflected in the statement of principles on which our delegates took action when they supported S. 1606.

Senator DONNELL. You didn't have S. 545 or anything similar at that time. It hadn't come into existence at that time. When you are saying it "brings us to the conclusions," and so forth, nobody has come to all these conclusions other than yourself. You are talking about yourself, isn't that right?

Mr. ANDERSON. Well, Senator, the association does come to conclusions and reaches agreement on certain principles. Those principles were adopted in 1946 and also by resolution still stand. Therefore, we can apply that test to any new legislation which may come, and, therefore, I feel I am on sound ground speaking for the association that we are in opposition to legislation which does not provide the same kind of principles that were provided in S. 1606.

Senator DONNELL. In other words, Mr. Anderson, there was a statement of general principles laid down in May of 1946 and you draw the conclusion from those principles that Section 712 (4) (a) that this objective cannot be achieved through this bill S. 545?

Mr. ANDERSON. That is right.

Senator DONNELL. You cannot set forth any official action of your organization except you are going to provide us with a copy of that resolution in May 1946 which is an expression of principle, is that right?

Mr. ANDERSON. That is right.

Senator DONNELL. Nobody in your organization but Joseph P. Anderson has officially issued any expression of opinion on either these two bills, S. 1320 or S. 545, is that correct?

Mr. ANDERSON. That is a correct statement, Senator. However, I would like to add that organizations like ours that are devoted to the study of these programs can't possibly take action in time. We can't call a meeting; we can't have a representation to take action on specific legislation, and, therefore, we must develop a statement of principles and then the employed executive officer is empowered to present testimony reflecting the point of view that is adopted in that statement. Now, however, as you say, there was no official action taken.

Senator DONNELL. May I say to you, that promptly at 12 o'clock this committee will be in recess for what we hope will be only a few minutes. Under the present law we are not authorized to sit while the Senate is in session. We expect to resume very shortly. I shall have to recess this committee promptly at 12 and you may resume your testimony, if you have not finished at that time, when we again convene.

Mr. ANDERSON. Thank you. To carry out the provisions of 712 (4) (a) will be necessary to establish policies and procedures to be used in determining whether individuals or families have "insufficient income to pay" the whole cost of needed medical care. This is the statement I was trying to get at but didn't quite make the grade. Social workers have had the responsibility for determining eligibility for various forms of assistance in many different kinds of programs of service. It is likely that if this bill becomes law a large number of social workers will have to be employed in administering this phase of the program. If that happens I am sure that social workers will perform this part of the job to the best of their abilities. In view of our experiences, however—I think we are particularly qualified to talk about it as we have been working at this a long time—I would like to express the opinion that the application of the policies and procedures to determine eligibility for assistance under this program will be cumbersome, costly, and demoralizing to the recipients. Although it is not stated in the bill, the carrying out of these provisions would result in establishing a category of medically indigent individuals and families in our population. A medically indigent person might be defined as one who can provide for the ordinary necessities of life but cannot meet unexpected and heavy bills for medical care.

Although a formula could be developed for deciding when an individual or family should be declared medically indigent, it would be impossible to work out any that would be satisfactory. I am suggesting this as an indication of what some of the difficulties would be. The question, for example, of what should constitute income for the purpose of determining eligibility for the service under this act is one that is not easy to answer. Should the income be of the head of the family or all members of the family, including relatives? Is it current income as reflected in the amount received for the pay period immediately preceding the request for assistance, or is it a figure arrived at by averaging income for a period of several months or a year immediately preceding the date of the request? Or should an effort be made to anticipate income of the family for a period immediately following the date of the request?

Senator DONNELL. If I might interrupt, all those questions are raised under the administration of the Social Security Act, are they not?

Mr. ANDERSON. They don't arise in quite the same way. They do arise—yes.

Senator DONNELL. They are solved by the respective States over the country, is that right?

Mr. ANDERSON. That is right. This isn't in complete satisfaction with the formula that has been worked out, but it is workable and they are doing it.

Senator DONNELL. The different Social Security Departments in the various States are administering vast sums of money and disbursing them, under the local statutes, to worthy recipients.

Mr. ANDERSON. A second consideration is the unpredictability of illness and the unpredictability of medical costs. It is impossible for an individual or family to anticipate the nature, occurrence, duration, or severity of illness. Unlike costs of food, shelter, and other necessities, medical costs cannot be budgeted accurately because the need for care and the amount required to pay for it cannot be estimated. These factors would necessitate a costly and cumbersome machinery in carrying out the provisions of S. 545.

An even more important consideration—this is one that another witness here this morning mentioned—is the demoralizing effect of a means test for determining eligibility on the industrious and self-supporting persons who may be in need of medical care. Modern social work practice is based on a fundamental respect for the dignity of every human being and on conviction of the need to conserve and reinforce the strengths of every individual. In the interest of enabling every individual to function adequately in a democratic society we urge the establishment of social protections against the common hazards which all of us at some time may have to face. That is why we have in other statements of principles supported programs which would provide the protections against unemployment, disability, old age—all these common hazards.

We are convinced that protection against the hazard of illness should be provided in the same way that a part of our population is now protected against death, unemployment, and disability of the principle wage-earner.

In financing a program of health and medical care we believe that—and this is from our statement of principles that we have arrived at after many years of study:

1. Public health, maternal child health services, medical research and training of professional personnel, construction of needed hospitals and health centers, medical care of the indigent and hospitalization of the chronically ill and mentally ill should be financed out of the public funds received by general taxation. These services should be financed on a Nation-wide basis with Federal and State participation and under conditions which would permit the Federal Government to equalize the burden of cost among the States.
2. Individual preventive, diagnostic, and therapeutic medical services for persons other than the indigent and the hospitalized chronically ill and mentally ill should be financed by a national system of compulsory contributory insurance supplemented by general routine from the Federal Government.

In view of the above considerations we believe that the objective of making available medical, hospital, dental, and public-health services to every individual regardless of race and economic status can be better achieved through S. 1320 and for that reason we endorse the general purposes, principles, and philosophy of that measure.

Senator DONNELL. Mr. Anderson, in the course of the latter part of your testimony, you expressed the belief that public-health investigators should be financed out of public funds or by general taxation. Has your organization gone on record on that particular proposition whether you favor the financing of those investigations out of funds received by general taxation?

Mr. Anderson. The statement of principles which was adopted in 1946 includes that statement.

Senator Donnell. I notice in your testimony when you appeared in April of last year before the predecessor committee, this sentence occurs:

> Is there anything under S. 1606 with reference to how the money is to be collected?
>
> We have not taken any stand whether it should be insurance or straight taxation.

I observe up until the time that you testified in April of last year there had been no expression by your organization as how the money should be handled, by insurance or through straight taxation. You hadn't taken up that question.

Mr. Anderson. That is right.

Senator Pepper. Mr. Anderson, I noticed that Mr. Henderson in his statement made the following declaration:

> Under the Taft bill the money for medical care cannot be spent to meet the medical needs until the presence of charity has been made and accepted. * * * An investigator cannot investigate more than 50 cases a day. If this bill is to assist 20 percent of the population, they will need between 600,000 to 1,200,000 man-days a year of the investigators' time to administer this bill.

Would you subscribe to those figures?

Mr. Anderson. Unquestionably, Senator. I am not in a position to state what the figure would be, but I am sure there would have to be a very large number of persons employed to discharge this part of the program.

Senator Pepper. You think that it will be extremely difficult to lay down a standard that will be applied to all people that will prove to be a workable standard?

Mr. Anderson. A means test under any circumstances is not an easy one to work out. I think when you bring it in to service a program of this kind that the difficulties are multiplied tremendously.

Senator Pepper. A means test, I believe, has been applied in respect to provision of old-age assistance under the social-security program, but if I remember correctly, the amounts of Federal contribution vary. The amount of money received varies from $16 a month in the State of the lowest contribution to $50 in the State of the highest contribution. So you are dealing only with limited sums of money there. The Federal contribution at the outside is fixed by law. I believe it is now $30 a month maximum Federal contribution. Is it a great deal easier, would you say, is it easier to determine how much of that figure between $16 and $56 a given individual should receive than it would be to determine whether the individual should receive the medical care contemplated by S. 1320—all kinds of medical care that the situation may require?

Mr. Anderson. I think it is very simple just to do that job.

Senator Pepper. And yet, even in respect to the old-age assistance, you have many difficult problems, don't you, as to whether a claimant should get old-age insurance? If he happens to own his own home but has no other income, whether or not if he rents a room in the house to a roomer he can still get the old-age assistance, and if a claimant has some savings in Government bonds salted away, whether these assets have to be expended before assistance will be granted, whether there are any members of the family who are able to support the applicant and to what extent they are able to do so—there are all those problems.

Mr. ANDERSON. Yes; and there you are dealing with people where there is not a person who can earn a wage. There is no problem of income from employment. Here we would be dealing with attempting to determine what is adequate income, not only to pay for the necessities of life but also to pay for medical care that is needed, and it is for that reason that we say the job can be done but it will be costly and it will be cumbersome.

Senator PEPPER. You might have the question of where a family has $500 in the bank and they have an illness. They have saved that $500 to buy an automobile. Now, shall they use that $500 to buy the automobile or shall the family do without the automobile and pay the $500 for the operation that is required? There are any number of such instances.

Mr. ANDERSON. $500 may be set aside to put the boy through college. The decision has to be made what they should use that for.

Senator PEPPER. On the contrary, if the family pays a given insurance premium per month, although it may be required by law, that is spent out of their income and is met out of their income. That goes into the common fund and while you have problems, of course, in the administration of the common fund, you get away from the means test difficulty.

Mr. ANDERSON. That is right. I would like to say just a word as to the philosophy back of the position which we have adopted. It was only in the last 6 or 8 years, I think, that we, as an association, have come to the decision that the program of——

Senator DONNELL. I am sorry to interrupt but the committee will be in recess for just a few minutes.

(A short recess was taken.)

Senator DONNELL. We will proceed. Mr. Anderson, were you just about to make a statement? Will you proceed?

Mr. ANDERSON. If I may just add this. We used to believe that it was very important just to provide certain kinds of services, and we have always known, of course, that in the matter of health and medical care that those services should be made available for all the people. Now we believe that the way in which those services are provided is also important, and that is why we have in the past 10 years been moving in the direction of and favoring the comprehensive program of social insurance. The reason we believe in having the program provided in this way is that we have learned that when a crisis hits an individual or a family that, depending on the strengths or weaknesses of that individual, he may either be able to take it and go along and remain self-supporting or he may go to pieces; he may want to escape. He becomes very resentful of the condition he has to face, and sometimes he turns that resentment inside on himself or, what is even more dangerous, he turns that resentment outward against legally constituted forms of authority. That is why we have farmers gathering at the market and that is why we have families on the street trying to prevent an eviction. There is a resentment that is caused by this feeling.

We feel, therefore, that people should not be subjected to this kind of experience, that we should set up the kind of system whereby the shocks that must necessarily come, whether in loss of employment or severe illness, could be cushioned by the kind of system whereby individuals will know they have had a part in planning and preparing for, and then they will be assured the right to getting care under that system.

Senator DONNELL. Any further questions? Thank you very much, Mr. Anderson, for your testimony. Now we will hear from Mr. Paterson.

Mr. CLORETY. I represent Mr. Paterson and will appear for him.

STATEMENT OF JOSEPH A. CLORETY, JR., AMERICAN VETERANS COMMITTEE

Senator DONNELL. Will you please state your name?

Mr. CLORETY. Joseph A. Clorety, Jr.

Senator DONNELL. You are an economist?

Mr. CLORETY. Yes, sir.

Senator DONNELLL. Please tell us whether or not you have prepared this statement that you are about to read.

Mr. CLORETY. The statement was prepared by Mr. Paterson, Mr. Newman, our public-relations director, and myself. It is based on a longer and more detailed statement which was prepared by a much broader group, Senator, including several doctors, two or three other economists, and Mr. Paterson.

Senator DONNELL. What doctors were there who participated in the preparation of this statement?

Mr. CLORETY. The leading doctors were the past and present chairmen of AVC in the New York chapter.

Senator DONNELL. Who are they?

Mr. CLORETY. Dr. Henry Macover, who is past chairman of that chapter, Dr. Norman Hesig, who is present chairman of that chapter. Dr. Richard Weinerman participated. He is chairman of the Washington area subcommittee on health.

Senator DONNELL. Any other doctors participated?

Mr. CLORETY. Not at that level, Senator. A great many doctors have participated in AVC's preparation of their position at our national conferences, both in 1946 and during the recent national conference in Milwaukee.

Senator DONNELL. I am talking about the preparation of this statement on which you are about to give the smaller statement.

Mr. CLORETY. No other doctors.

Senator DONNELL. Those are the three doctors that collaborated together with other gentlemen in the preparation of that statement? Will you proceed.

Mr. CLORETY. The American Veterans' Committee appreciates the opportunity to state its view on the national health bills now before this committee. We have prepared a more comprehensive statement for the record, if we may be allowed to submit it at this time. However, I would like to retain this until the close of my testimony and then offer it in.

Senator DONNELL. Mr. Clorety, this is very unsatisfactory to be handled this way. Under the statutes this committee is entitled, as I recall, to receive in advance statements of the witnesses so we may study them. Now you come in here with a brief to be submitted. We have had no opportunity to see it and now you want to hold it in your own hands until after you get through. We can't examine these statements at all in advance. You have handed me what is the very short statement.

Mr. CLORETY. Our understanding was that we would have only 15 minutes. We therefore compressed the statement and prepared this one for general release. We did not have time to prepare mimeographed copies of this.

Senator DONNELL. You will have leave to file it, but it is not at all satisfactory in my judgment under the terms of the statutes, because it doesn't give us an opportunity at all to study these statements which you will make and to ask any questions. You say you want to hold it until you are finished. The best we could do would be to glance at this statement if you handed it to us now. I just want you to understand the situation in which such procedure leaves us.

Mr. CLORETY. I am sorry that took place, Senator. The fact of the matter is that our national office has been rather disrupted due to the national convention.

Senator DONNELL. You may proceed. You have leave to file this more amplified statement.

Mr. CLORETY. Thank you. All of the salient points are in the short statement.

Senator DONNELL. Very well. Proceed.

Mr. CLORETY. We propose now to indicate our general position with enough brevity to stay within our time limit.

As a national organization of citizen veterans, the AVC is vitally concerned with the health problems of the country. We learned, through the ugly experience of war, that physical fitness and adequate medical care is vital to the people who comprise our Nation. We are convinced that the first step toward better national health is the enactment of a real national health program.

Such a program has been embodied in the comprehensive provisions of S. 1320, the national health insurance and public health bill of 1947. The AVC expressed its endorsement of such legislation at its last annual convention.

Senator DONNELL. You mean the one last week?

Mr. CLORETY. This reference is to the convention in 1946. The 1947 convention has reiterated that stand, and I propose to read into the record the plank which was adopted last week.

Senator DONNELL. Very well. The one in 1946 was related to S. 1606, as S. 1320 had not been introduced as yet?

Mr. CLORETY. That is correct, Senator. And has explained its position in testimony during the Senate committee health bill hearings of 1946. The new bill, S. 1320, represents an admirable redrafting of S. 1606 in line with the responsible criticisms made last year. The emphasis on local administration, individual rights, and rural welfare in S. 1320 deserves—and receives—our full support. Certainly, nothing has occurred to lessen the pressing need for a national medical-care program since the ample evidence presented to the Senate committee last spring.

It is against this background that we have studied S. 545. And we are convinced that, when measured against the needs of our people, this bill falls short on every count. It is avowedly a political substitute for health insurance, and not a positive program at all.

Senator Donnell. Who has "avowed" that?

Mr. Clorety. Senator Taft, earlier in this session of Congress, made an extended radio speech on the program he was presenting. In that presentation he emphasized that he was presenting this program, which embodies S. 545, as a substitute for the Murray-Wagner-Dingell bill.

Senator Donnell. Did he say a "political substitute"?

Mr. Clorety. I would think that the Senator would avow that any legislation before Congress which was presented by either party would be a "political bill."

Senator Donnell. You mean that any piece of legislation is a political bill; is that right?

Mr. Clorety. Certainly, Senator.

Senator Donnell. I would think when you come in and say, "It is avowedly a political substitute for health insurance and not a positive program at all," that you are not expressing either the motives or the thoughts of the people who were behind S. 545. Do you mean exactly what you say—that S. 545 is a political substitute gotten up for a political substitute to avow something that has taken place? If anybody avowed anything like that, I would like to have you tell us who? What do you mean by the use of your word "avowedly"?

Mr. Clorety. This bill S. 545 was avowedly a substitute to meet a problem of the first water, one on which the people of this country feel very deeply. It is a major political problem. The Murray-Wagner-Dingell bill is one answer. S. 545 is a substitute to that problem. It is a political substitute. I recognize that it may sound blunt and an inflammatory statement but it is less inflammatory than the remarks about socialized medicine which the opposition to our position frequently use.

Senator Donnell. Your AVC, in the course of its estimates or principles, advocates that candidates who oppose certain things should be exposed. Is that the language you used in your declaration of principles?

Mr. Clorety. That is not the language, Senator.

Senator Donnell. I think you do. I think you refer to the word "exposed." But I shall offer here—I don't have it at the moment—I shall put in a portion of what appears in the record and was placed in the record by Senator Murray, last year I think it was, of the declaration of principles of the American Veterans Committee. I believe it stated in substance that its principles were to expose candidates who opposed certain legislation.

Mr. Clorety. With all due deference, you must be mistaken. We do not wish to have our position interpreted as any attempt to reflect upon the motives of thousands on this legislation.

Senator Pepper. You have a right to say anything you want to about anybody in this country, haven't you?

Senator Donnell. Why certainly they do, Senator Pepper. But the point I am getting at, when a man comes in here like Mr. Henderson did this morning and declares that this bill is a "political sop," and then another man comes in here and says it is avowedly a political substitute for health insurance and not a positive program at all, and when he comes in representing an organization which has among itself or in its declaration of principles—I am very confident of the use—I am sure that statement meant it would expose legislative candidates. I take it that this organization is obviously using strong language. However, that is a matter of organization and it shall be offered in the record—that particular portion of your declaration of principles to which I refer.

Mr. CLORETY. We have a very short statement of our declaration of principles. Would you place in the entire statement?

Senator DONNELL. I will place in the entire statement. I will put in the whole thing from A to Z.

Mr. CLORETY. Thank you.

Senator DONNELL. Proceed.

Mr. CLORETY. By freezing the present inadequate pattern of medical care, S. 545 postpones any real progress for an incalculable number of years.

Our objections to S. 545 can be briefly listed, although time does not permit an adequate development of each point:

1. S. 545 is basically a charity scheme for those who will submit to a means test. Straight hand-out medicine would be offered—and then to only about 10 percent of the people. The majority of families who are not indigent, but who badly need a better system of medical care, are not considered. The title "National Health Bill" is a misnomer.

2. S. 545 implies that voluntary plans can care for the vast majority of the Nation, although most existing plans are far too restricted in benefits, too costly, too limited in location, and too undemocratic in structure ever to reach more than the fraction of urban people now covered.

3. S. 545 is devoid of standards and guaranties of quality. In effect it increases the disparity in the present double standard of medical services—one kind of medical care for the needy and a different brand for the paying patients.

4. S. 545, through many of its provisions, assures the dominance of the program by the American Medical Association, whose past record of opposition to every phase of health progress in America is unbroken. The American Medical Association is now supporting State legislation which outlaws any voluntary prepayment plans not dominated by its own local medical societies, thus attacking the group-health associations throughout the country. Obviously, the American Medical Association is not even completely sincere in its stated approval of voluntary health-insurance plans.

Senator DONNELL. You don't regard the American Medical Association as sincere in its observation; is that correct?

Mr. CLORETY. With respect to this program, Senator?

Senator DONNELL. Yes.

Mr. CLORETY. No, sir; we do not.

Senator DONNELL. You regard the organization, consisting of 80 to 90 percent of the practicing physicians of this country—135,000 or thereabouts—as insincere in the position it takes; is that correct?

Mr. CLORETY. That is our position, Senator.

Senator DONNELL. Very well.

Mr. CLORETY. We do recognize doctors that make contributions. We recognize the contributions of the American Medical Association to scientific programs, but in this field we do not regard their contributions as anything other than negative.

Senator Donnell. You have a perfect right, Mr. Clorety, to present your opinion. I am not criticizing or saying what you should or should not do. I want it perfectly clear that you are meaning what you say, namely, that you say the American Medical Association, consisting of 80 or 90 percent of the practicing physicians, is not sincere in the matter of volunteer health insurance plans; is that what you say?

Mr. Clorety. That is what we say, Senator, and we believe the record will bear us out.

Senator Donnell. Go ahead.

Senator Pepper. Mr. Clorety, did you distinguish between the private opinions of the great mass of practicing physicians of this country and the official expressions and actions of the American Medical Association through official spokesmen?

Mr. Clorety. Yes, Senator. Perhaps I should better answer that question by reading from this more extensive statement. We say in that respect that we admire the scientific achievements of the American Medical Association, but our history books convince us that the social philosophy and public record of organized medicine leave much to be desired. The American Medical Association has regularly opposed every stage of health progress—public health departments, workmen's compensation laws, voluntary hospitalization insurance, group health associations, and the like.

I might add to that they opposed the program which Congress voted to give medical care to the wives of servicemen who were pregnant during the war. We do differentiate between the individual physician and the American Medical Association.

Senator Donnell. You think that the American Medical Association, speaking officially, is insincere, although you contend that individual doctors, insofar as you know, are sincere; is that right?

Mr. Clorety. Yes; that is a very true statement. In fact, we will publicly stand up and say we know various numbers of doctors who are personally sincere.

Senator Donnell. You understand that the American Medical Association speaks through its house of delegates. Do you not know that to be true?

Mr. Clorety. Yes, sir.

Senator Donnell. That organization is selected from all over the United States and represents the doctors of the respective communities. You know that, do you not?

Mr. Clorety. Yes; we do, Senator.

Senator Donnell. Does it strike you as peculiar at all that men who are honest would lose their sincerity and their honesty when in a representative capacity? Doesn't that strike you as rather peculiar?

Mr. Clorety. It is a pattern which is not unfamiliar, Senator.

Senator Donnell. A pattern of honest men coming together and then losing their sincerity when they get into a gathering of men—is that what you find quite common, do you?

Mr. Clorety. Among Nation-wide organizations I think that the records will show that does happen.

Senator Donnell. You think any national organization consisting of 80 or 90 percent of men who are perfectly honest and sincere, but somehow the program that emerges is one that cannot be labeled honest and sincere; is that your point?

Mr. CLORETY. Yes, Senator.

Senator DONNELL. Would you say that the AVC, although it is composed of honest men, when they come out with a plan it is insincere in relationship to their opinions?

Mr. CLORETY. No; I don't think so, Senator, because perhaps we are not old enough yet.

Senator DONNELL. You think with the added years you may acquire that characteristic, too; is that right?

Mr. CLORETY. It is possible that we will, but some of us will fight against it.

Senator DONNELL. Mr. Clorety, do you mean to come here and affirmatively state that if 130,000 doctors, who are individually honest, have formed an organization and elected their representatives to that organization right out of their own midst—honest men—that there is any sense or judgment in saying that those men, when they come together in the house of delegates of that organization are going to lose their honesty and become insincere; do you want to leave that impression?

Mr. CLORETY. The men themselves will not. We are criticizing the stand that the American Medical Association takes. We are not criticizing individuals here.

Senator DONNELL. You state, and I quote:

> Obviously, the American Medical Association is not even completely sincere in its stated approval of voluntary health insurance plans.

That approval is constituted of the votes of men in the house of delegates; is that right?

Mr. CLORETY. Yes, Senator.

Senator DONNELL. Therefore, in order to make a statement of approval of voluntary health insurance plans the votes are—or what constitutes that approval is evidenced by the result of the vote; is it not?

Mr. CLORETY. It is.

Senator DONNELL. All right. Now, you mean to tell us that men that come there and cast their votes are a sort of Dr. Jekyll and Mr. Hyde. When home they are all right. They are Dr. Jekyll. They are perfectly honest and upright ctizens. When they come to go to the house of delegates and vote, they lose their sincerity and cast their votes for something they don't believe. Do you mean to tell us that?

Mr. CLORETY. Our understanding on that is based on the fact that, whereas they endorse in their house of delegates the principle of voluntary health insurance in the various States of the Union, they are doing their best to knock out those plans, unless the plans are placed right in the hands of the local medical society on the terms that the local medical societies demand.

Senator DONNELL. That wasn't the question. Do you mean to tell this committee that when the man who comes to the house of delegates, who individually is considered as an honest man—you would say that practically all of them are honest, wouldn't you say, as individuals?

Mr. CLORETY. Certainly.

Senator DONNELL. Do you mean to say that when they get into the house of delegates and cast their ballots or their votes on the measure before the house of delegates, those men cast off their characteristics as honest men and substitute this character of insincerity in voting in favor of the measure that they don't believe in? Do you mean to tell that to the committee?

Mr. CLORETY. That is not my position.

Senator DONNELL. What is your position?

Mr. CLORETY. Our position is that the American Medical Association, as such, cannot be completely sincere in its stated approval of voluntary health programs since it goes to work and adopts voluntary health programs. Now, whether that takes place in the house of delegates or in the executive offices of the association, I don't know. I just know the public record of the American Medical Association.

Senator DONNELL. What do you think about the sincerity of the AMA in its opposition to compulsory health insurance? You think it is sincere in that opposition?

Mr. CLORETY. I believe it is perfectly sincere in that opposition.

Senator DONNELL. You think they are sincere in that, but that they are just insincere in the matter of voluntary health insurance? Why are they sincere on one thing and insincere on another?

Mr. CLORETY. I cannot account for it, but I say that it is obviously insincere when you place, on the one hand, their position in the approval of group health association or voluntary prepayment plan, and then see their records out in the various States of the Union where they are opposed to that.

Senator DONNELL. All right. Go ahead, Mr. Clorety.

Mr. CLORETY. The American Veterans' Committee respectfully urges that any national health program be placed in the hands of administrators responsible to the public, and not in the control of a private doctors' association.

5. S. 545 ignores the basic problems of local public health services, maintenance of local hospitals, increase and redistribution of medical personnel, support of medical education and research, and encouragement of group practice—all of which are embodied in S. 1320.

6. S. 545 is administratively chaotic, multiplying, as it does, the number of Federal health offices, superimposing a new political doctor over the Surgeon General of the Public Health Service, allowing the delegation of medical-service responsibilities to private agencies, and establishing a matching-grant formula which is unfair to the poorer States. The elaborate investigative machinery necessary to ascertain the financial status of all patients can well be imagined. A basic error of the bill is its unscientific separation of preventive and curative medical activities.

7. Finally, the funds authorized are totally insufficient even to finance those charity benefits which are provided in the bill.

Section 2 (c) of S. 545 states that—

> it is the policy of the United States to Aid the States * * * to make available medical, hospital, dental, and public health services to every individual, regardless of race or economic status.

We submit that this stirring purpose is actually denied by the rest of S. 545, but is effectively embodied in the comprehensive provisions of S. 1320. As citizen-veterans, therefore, we urge your favorable consideration of the national health insurance and public health bill of 1947.

I would like now, Senator, to read the plank on national health legislation which was adopted by the second annual convention of the American Veterans' Committee in Milwaukee, Wis., June 19–20, 1947:

> The health of every citizen is the concern of the Nation. Only a Nation-wide mobilization of resources can assure adequate health care to every American. We, therefore, favor a comprehensive national health program, to include Federal aid to the States for the establishment of community-wide preventive health services in every county, compulsory health insurance to provide adequate personal medical care for all persons, an extension of social-security benefits as they relate to health, particularly health-care provisions for the indigent, and cash disability compensation.
>
> As complementary and reinforcing health programs, we favor Federal assistance for medical research and education, a national mental health program, a national school health program, a national program for dental research and dental health care, and a national cancer-control program. We urge, furthermore, the liberalizing of the appropriations and the eligibility provisions in the Hospital Survey and Construction Act, so as to insure the adequate development of hospital facilities in the rural and economically depressed areas. We believe that the first and most realistic step toward the ends we support is the immediate passage of the Wagner-Murray-Dingell bill.

Senator DONNELL. Thank you.

(Mr. Clorety submitted the following brief:)

AMERICAN VETERANS' COMMITTEE STATEMENT ON S. 545, EIGHTIETH CONGRESS, 1947—THE TAFT-SMITH-BALL-DONNELL NATIONAL HEALTH BILL

The American Veterans' Committee, as a national organization of citizen-veterans, is vitally concerned with the health problems of our country. We saw, in the ugly demonstration of war, the basic importance of physical fitness and the tremendous significance of adequate and available medical care. We are impressed with the potentialities of modern medical science, and are convinced that America has the resources and the ability to bring its full benefits to all our people.

That a challenging gap exists today between the best of medical science and the average of medical care available to the population has been voluminously demonstrated in the testimony offered to Senate committees in the past few years. Today, this knowledge has given rise to a vast demand for an adequate national health program. There is no longer reason for debate as to the need. The question now is one of method.

At its first constitutional convention in June 1946, the AVC passed the following statement on health:

"The health of every citizen is the concern of the Nation. We therefore favor a comprehensive national health program to include hospital planning and construction, Federal aid for the establishment of community-wide health service, compulsory health insurance to provide adequate personal medical care for all citizens, extension of social-security protection as it relates to health, particularly disability compensation, and establishment of an adequate mental health program.

During last year's hearings on health legislation, AVC submitted its case, from the veterans' viewpoint, for a national health program. Nothing has occurred in the interim since June 1946 to indicate any lessened need for a comprehensive approach to the health problem. Our veteran members were happy to see the hospital construction and mental-health programs passed by the Seventy-ninth Congress. We look forward to the achievement of the remainder of our basic health platform. Unfortunately, however, the provisions of S. 545 seem to fall far short of the demonstrated requirements for national health. S. 545 not only omits the fundamentals of health insurance and preventive health services, but it introduces new elements that are actually detrimental to the case of the Nation's welfare.

VA MEDICAL BENEFITS

The motto of the American Veterans' Committee is "Citizens first, veterans second." We are looking for no special pork barrel for ex-servicemen. But we do demand progress toward general social security in which we can take over proper places. We reject the inferences of many spokesmen for the medical status quo that we are now fully covered by the Veterans' Administration program. VA medical benefits are restricted to care of service-connected disabilities and, in the case of nonmilitary troubles, to hospital services for those veterans who take a pauper's oath. (We will have more to say later about our feelings concerning the means test.) Our families, of course, remain completely untouched by our GI medical benefits. Thus, the vast bulk of our health needs are as much of a cause for concern to us as to our nonveteran fellow citizens. For these reasons we have vigorously supported the proposals for a national health insurance program designed to reach all families with the protection of prepaid medical care.

EVALUATION OF S. 545

It is against this background that we have studied S. 545. We feel that adequate medical care is a right of all American citizens. We looked hopefully to the new congressional leadership for some indication that our health problems were not to be minimized. Unhappily, we cannot find such evidence in this bill. It dodges the main issues. It blocks the door to real progress. It embodies anachronistic policies. We know that Congress can do better. Congressional proposals for a national health insurance plan (S. 1320) already demonstrate this:

In the first place, S. 545 is avowedly a substitute for national health insurance. By freezing the present pattern of chaotic medical organization, it would postpone for a heartbreaking number of years the establishment of insurance protection for all citizens. We submit that a State-supported charity program for a few of us is a poor substitute for a self-supported health insurance system of complete care for practically all of us.

AMA CONTROL

Secondly, we are very frankly worried about the fact that the administrative provisions of this bill will result in the domination of the program by the American Medical Association. We respect the physicians of this country. We admire the scientific achievements of the AMA. But our history books convince us that the social philosophy and public record of organized medicine leave much to be desired. The AMA, has regularly opposed every stage of health progress—public health departments, workmen's compensation laws, voluntary hospitalization insurance, group health associations, and the like. When Congress voted help to servicemen for medical care during their wives' pregnancies and their infants' early days, the AMA protested violently.

The AMA hierarchy now controls every aspect of health activity except public programs administered by national agencies and the remaining few group health plans. S. 545 would complete their monopoly. The provisions in the bill that the national health administrator must be a doctor in private practice, that a doctor-dominated council would have administrative veto powers, and that State programs can be effected through private medical organizations would put the old guard of organized medicine in solid control.

This bill would, furthermore, help to finance the current AMA war against the consumer-controlled health cooperatives and give a badly needed financial shot in the arm to the shaky medical society plans. The medical societies have already been instrumental in outlawing group health plans in over 20 States, and are gunning for the rest. S. 545 allows the States to pay the premiums in behalf of their needy clients to voluntary prepayment plans. No crystal ball is needed to know that the powerful State medical societies will advise the selection of only the AMA controlled plans. And a danger all of its own is the fact that the usual medical society prepayment plan offers only surgical and maternity care during hospitalization—thus providing only a segment of full medical care even to those relatively few needy folks who might be covered.

When a national health program is set up, the AVC respectfully urges that it be placed in the hands of experienced administrators responsible to the public, and not in the control of a private association representing only the purveyors of this service.

WEAK MEDICAL SERVICE

The heart of the bill is its section on "General medical service for families and individuals with low income." Here the issue is squarely joined: Charity medicine versus health insurance. And the AVC can find no room for compromise when it comes to opposing any labeling of Americans with a means test. No one stood at the tent flap of the battlefield aid station to ask us what our income was. And the means test idea in S. 545 still rankles.

Every study ever made, including the AMA's own, has shown that fully 80 percent of our population have trouble at one time or another in paying their full medical care bills under the present arrangement. Obviously, a free, State-supported medical system for 80 percent of our population is not the purpose of this bill. But equally obvious is the undesirability of requiring extensive financial investigation to discover which few of this 80 percent can get the charity benefits described in S. 545.

Senator Taft has stated that the bill is intended for about 20 percent of the people. The money it authorizes, however, constitutes less than 10 percent of the total sums now being spent for medical services by the country. Yet at least 80 percent of our fellow citizens are looking hopefully for a national plan of better health care into which they can pay their own way. The clear answer is that of national health insurance, whereby everyone contributes according to his ability, comprehensive medical care is made equally available for all families and the poor take their dignified place in a unified program that rejects any double standards. S. 545 just doesn't guarantee these rights of the people—and the little it does do is wrapped up in very unpopular provisions. Surely the poor laws of Elizabethan England are no proper model for the American health legislation of 1947.

Not only are the benefits of this bill limited to the indigent, but the quantity and quality of the services are nowhere defined or guaranteed. The States are left the options of providing care in the homes, or doctors' offices, or hospitals. If Medical Society or Blue Cross plans are used, only partial services will be rendered. And, furthermore, if the bill assumes that voluntary plans are now or ever could be available to more than the urban middle class fraction of the population, the lessons of the whole American and Europeain experience have been lost.

The bill sets no standards of quality—even minimal ones. The physician in charge of the program is specifically enjoined from rejecting any State plan because of its methods. No qualifications are required for the participation of private plans or voluntary agencies. Preventive services and public health activities are ignored. Group practice, laboratory services, medical research and education are not considered. One begins to wonder if this bill would do anything beyond changing the administrative pattern of current welfare medical activities.

The two basic medical care needs of the country are for more and better hospital facilities and medical personnel. The Hospital Construction Act will have little effect in the low-income areas of greatest need unless local upkeep can be guaranteed. Health insurance would produce this necessary local hospitalization purchasing power. S. 545, however, avoids this issue. Health insurance would also guarantee good incomes to doctors, nurses, etc. in rural and other underserviced areas. S. 545 does allude to special payments for rural doctors but requires that this money come from the skimpy general appropriations. The serious personnel problem goes actually unsolved. Nothing at all is proposed to meet the additional need for nurses, dentists, school health, educators, and the like.

Thus, we are offered a program that does little or nothing to increase the services or improve the quality of medical care so badly needed by our people. As veterans hoping to find that social progress is to be the reward for the long years of war, we are deeply disappointed by this bill.

ADMINISTRATIVE DEFICIENCIES

We are no experts on administration, but even to our inexperienced eyes this program appears to be administratively chaotic. A new medical care agency appears with the solitary function of rubber-stamping State plans. It has no relation to the other grant-in-aid functions of the Public Health Service. A new dental care agency appears with no relation to the dental research program. A new politically appointed doctor appears to outrank the Surgeon General of the PHS, a career service officer. The Federal-States matching formula penalizes the poorer States, makes it virtually impossible to figure out just what the State contribution must be, and leaves the way open for individual States to stay entirely out of this national health program if they get too confused.

The administrative sins seem endless. Advisory councils of private, part-time citizens are given veto powers over the public officials, and are top-heavy with representatives of the providers rather than the consumers of the health services. Some of the top officials are required to be doctors with long years of private practice, as if the family doctor's experience makes him a good Federal administrator.

Most important of all are the provisions allowing any voluntary agencies or private organizations to be delegated the medical care responsibilities, without even minimal standards to meet and without any public control over the use of public funds. AVC'ers would prefer their tax money to be expended by their State and National Government on whom they can keep tabs through the legislatures, rather than by the executive secretaries of the various private medical societies.

A REAL PROGRAM FOR NATIONAL HEALTH

The bill contains many more provisions of doubtful validity. But it is not our purpose to suggest a reconstruction of this basically unworthy measure. Not when the far more preferable alternative of national health insurance (as embodied in S. 1320) exists on the docket for consideration. For, in rewriting S. 545 it would be necessary not only to clean out the charity stigmas, revamp the administrative sections, and reexamine the matter of funds—but it would also be necessary to start from scratch in writing in the essentials of a truly national health plan. This would involve provisions for local public-health services, maternal and child health care, medical education and research, minimum standards of quality, definitions of acceptable professional personnel and agencies, and of course personal medical care services available to all who need them. This really means an abandonment of S. 545 and an endorsement of the more comprehensive measure S. 1320. This, in a nutshell, is the earnest recommendation of the American Veterans' Committee.

Our people—veterans as well as nonveterans—need certain program foundations on which to build a healthy nation. We need adequate public health units in every community. We need the means of supporting more hospitals and of stimulating the redistribution of doctors. And we need a system that will transfer the burden of medical expenses from the shoulders of the incapacitated and the sick to the whole of our society. S. 545 does none of these, and shackles the little medical care it does offer with the stigma of charity and the handcuffs of near-impossible administrative machinery. S. 1320, however, seems specifically designed to meet the basic needs of all the people. The new version of the health insurance bill, with its emphasis upon local administration; individual rights, and rural welfare, surely deserves the support of all who have the health of the Nation at heart.

National health insurance has been attacked with primarily these types of arguments: Bureaucracy, State paternalism, deterioration of standards, lack of freedom of choice of physician, and loss of individual dignity. It strikes us forciby that such a program as that called for by President Truman gives no evidence at all for the justification of such charges. But S. 545 seems actually to embody them all. The bureaucracy of personal financial investigations would be fabulous; the provision for straight State medical charity is the ultimate in paternalism; the absence of any quality standards in the bill is unpardonable; nowhere is there the slightest mention of free choice of physician and never has the AMA protested the matter in this bill; the pauper's oath is probably the most potent force known for the destruction of individual dignity and self-respect. If the critics using these arguments are really sincere, we anticipate their complete rejection of the charity medicine plan and their espousal of universal health insurance in America.

In closing, we would announce our full support of one section of S. 545. Section 2 (c) on page 2 of the bill gives its basic purpose. Senators Taft, Smith, Ball, and Donnell state that "It is the policy of the United States to aid the States * * * to make available medical, hospital, dental, and pubic heath services to every individual regardless of race or economic status."

This is a thrilling statement. But it must be admitted by everyone who reads S. 545 that actually no pretense is made by the bill to achieve such complete care for all our people. Every individual who supports the policy just quoted, however, must, in all sincerity, accept the fact that far more careful planning is necessary to provide "medical, hospital, dental, and public health services to every individual regardless of race or economic status."

Such objectives are obtainable, however, through S. 1320, the National Health Insurance Act of 1947.

Senator PEPPER. I ask leave to insert in the record at this time a statement of what Dr. Morris Fishbein would have heard if he had listened in on an interview with Dr. H. Guy Dain relative to the rendering of medical care in the British Empire.

Senator DONNELL. It will be inserted in the record.

(The statement referred to follows:)

[From PM, Tuesday, July 1, 1947]

(By Albert Deutsch)

BRITISH DOCTORS FAVOR FREE MEDICAL CARE FOR ALL, NOTED EXPERT SAYS

The conservative heads of the British Medical Association (BMA) sound like red-hot Commies when compared with the hierarchs who rule the American Medical Association. If Dr. Morris Fishbein had listened in on an interview with Dr. H. Guy Dain at the Centennial Celebration meeting of the AMA in Atlantic City last week, he might have rushed out wildly and sent a three-alarm call to J. Parnell Thomas, John E. Rankin, and J. Edgar Hoover.

Dr. Dain, distinguished British surgeon, is chairman of the council of the BMA, and was an "honored invited guest" of the AMA. What a difference between his picture of British medicine operating under a national health insurance system and that painted in the official organ of the AMA. When the AMA wants to show the evils of a national health insurance program in this country, it often points to the "horrifying example" of Great Britain, where "regimented doctors" are "enslaved by the state" and dispense low-grade medicine to victimized patients.

ORGANIZED MEDICINE IN BRITAIN NOT SCARED BY STATE MEDICINE

Having had a national health insurance system since 1911, the British are about to take a real revolutionary plunge into state medicine. The National Health Act passed by Parliament earlier this year provides that, beginning April 1, 1948, all medical and health services will be available free to every Britisher, from dishwasher to duke, with all doctors on the Government pay roll. All services will be financed by tax funds, unlike the present insurance system in Britain and the very modest insurance program envisaged by the Wagner-Murray-Dingell bill here.

How have British doctors reacted to the new system which has already been spread on the statute books?

"British medicine," Dr. Dain answers, "is in favor of a National Health Service. By that we mean free medicine everywhere, for everybody, including every medical service. We are not afraid of so-called socialization of medicine, nor are we frightened by the proposal that full medical services be made available by the state to all citizens.

"We do, however, object, and object very strenuously, to several details in the present act. The British medical profession is now engaged in negotiations with the National Health Ministry aimed at mutually satisfactory settlement of these disputed points."

Dr. Dain listed these main objections to the National Health Act advanced by the BMA, which comprises a membership of 55,000 out of Britain's 70,000 physicians:

The act provides for Government ownership of all hospitals (excepting private nursing homes), contemplating that the Government will make suitable financial arrangements for the transfer of all institutions now being operated on a voluntary nonprofit or proprietary basis. The BMA opposes this "monopoly of hospital services" by the British Government.

OBJECTS TO BAN ON SALES OF GOOD WILL IN PRACTICES

The act makes it illegal for one doctor to sell the goodwill of his practice to another. The BMA feels that doctors, especially those in old established practices, have built up considerable goodwill investments which ought to be salable and purchasable as are other businesses. The Government is proposing methods of fair appraisals and governmental remuneration for practices which doctors give up through retirement or removal to other areas. This point is one of the touchiest among those in dispute.

The BMA opposes the plan to put all doctors on state salary, as proposed in the National Health Act. On the other hand, it does not insist, as the AMA does, on a retention of the fee-for-service system, whereby a doctor is paid for every individual call or other service.

"We do not object to a capitation system," says Dr. Dain. (Under capitation, the doctor is paid on the basis of the number of patients he has on his panel, regardless of the number of services he renders throughout the year.)

A clause in the National Health Act empowers the Health Minister to order any doctor to move and practice in an area where his services are needed. Dr. Dain points out that there is a similar clause in the old act establishing national health insurance, but it has been resorted to only once during the past 30 years, and that most doctors aren't afraid that the power would be abused in the future.

"But we don't like the idea of a statutory provision enabling anybody to tell a doctor where he can and must practice," he adds. "We are jealous of our freedom."

"Has the health-insurance system in England interfered with the freedom of the medical profession?" Dr. Dain was asked.

"Absolutely not," he replied.

"Some opponents of national health insurance here claim that the system has led to a deterioration of medical practice in Britain. Is that true?"

"Decidedly not. It hasn't harmed the British doctor ethically, scientifically, or economically. Those who say different simply don't know the facts.'"

Dr. Fishbein, please note.

Senator DONNELL. Is Mrs. Evanson here now? Will you please state your name?

STATEMENT OF MRS. JEROME EVANSON, REPRESENTING THE NATIONAL FARMERS UNION AND THE NORTH DAKOTA FARMERS UNION

Mrs. EVANSON. I am Mrs. Jerome Evanson, of Jamestown.

Senator DONNELL. Do you have copies of your statement ready?

Mrs. EVANSON. I am sorry. I got in too late to have them mimeographed. They will be here in the morning.

Senator DONNELL. You understand that is not in compliance with the rules of this committee.

Mrs. EVANSON. I am sorry.

Senator DONNELL. The committee is deprived of the opportunity to examine your statement in advance. We can't do anything but listen and to catch it on the run. It is not at all satisfactory. When was your plane due here?

Mrs. EVANSON. I was to have gotten in last night but I missed my plane out of Fargo.

Senator DONNELL. Weren't you notified to get your statement in 72 hours in advance?

Mrs. EVANSON. I was not.

Senator DONNELL. Didn't you get a telegram to that effect?

Mrs. EVANSON. No. I have never done anything like that. I intended to have it mimeographed when I got here but I didn't get in in time.

Senator DONNELL. All right. Will you state what organization you represent and your official capacity?

Mrs. EVANSON. I am director of education of the North Dakota Farmers Union.

Senator Donnell. Has your organization passed any resolutions with respect to S. 545 or S. 1320?

Mrs. Evanson. Not since we had our national convention. We had our convention last fall. That was before the bill S. 545 was introduced.

Senator Donnell. Just what authority do you have then to express the opinion with regard to these two bills?

Mrs. Evanson. I was authorized by national to represent the national organization.

Senator Donnell. Who was it who authorized you on behalf of the national organization?

Mrs. Evanson. Mrs. Gladys Edwards, director of education, and James Patton.

Senator Donnell. You don't know whether any meeting of the National Farmers Union discussed that subject?

Mrs. Evanson. Not since S. 545 has been introduced.

Senator Donnell. Not since S. 1320 has been introduced, either?

Mrs. Evanson. That is right.

Senator Donnell. Well, then, I am puzzled to know just how you can express opinions on behalf of the National Farmers Union when it hasn't expressed those opinions with respect to these two particular bills. Have you read S. 1320?

Mrs. Evanson. Yes.

Senator Donnell. Have you read S. 545?

Mrs. Evanson. Most of it; yes.

Senator Donnell. Not all of it?

Mrs. Evanson. I have gone over the whole bill. I haven't studied each part specifically.

Senator Donnell. Have you read it all?

Mrs. Evanson. Yes.

Senator Donnell. You have read all of S. 545?

Mrs. Evanson. Yes.

Senator Donnell. And you have read all of S. 1320?

Mrs. Evanson. Yes.

Senator Donnell. But I can't yet see how you can come in here speaking for the National Farmers Union unless there has been some authoritative expression from the National Farmers Union which approves what you say. Did you prepare this statement you are going to give yourself?

Mrs. Evanson. I prepared it.

Senator Donnell. Did they send along any schedule or any copy of resolutions that you were to base that statement on?

Mrs. Evanson. Merely the principles as set forth at our national convention. I also represent the North Dakota Farmers Union here today.

Senator Donnell. Those principles do not specifically refer to either of these two bills?

Mrs. Evanson. Hardly.

Senator Donnell. Mrs. Evanson, you have presented evidence on the part of these two organizations before?

Mrs. Evanson. Yes.

Senator Donnell. In regard to their general attitude on this bill?

Mrs. Evanson. Yes.

Senator DONNELL. What, in general, are those principles?

Mrs. EVANSON. To make health facilities available to all; that we move to promote ways and means of getting doctors into rural areas, hospitals into rural areas, and public-health services to cover all of the people.

Senator DONNELL. And have you personally adopted the principle of national health insurance?

Mrs. EVANSON. Yes.

Senator DONNELL. As a means of providing medical care?

Mrs. EVANSON. Yes; as it gives expression to our principles.

Senator DONNELL. Those principles have been declared by those organizations in the past that you are expressing here today?

Mrs. EVANSON. That is right.

Senator PEPPER. I want to apologize but I didn't know we would run so late and I have got to go to my office. We are glad to have you come down here and read into the record all of your statement in full.

Senator DONNELL. Mrs. Evanson, before you begin, you are from North Dakota or South Dakota?

Mrs. EVANSON. North Dakota.

Senator DONNELL. Were you present at the Health Workshop in Jamestown on September 27, 1946?

Mrs. EVANSON. Yes.

Senator DONNELL. Do you know how many Federal employees were present at that meeting?

Mrs. EVANSON. Yes.

Senator DONNELL. How many were present?

Mrs. EVANSON. I think there were about 18 or 19. There were three who came through and stopped overnight. There were, from Washington, 10. Three of them were not invited as consultants. They came to observe the techniques used in the workshop. We invited—since they told us we had gone over the head of the regional to invite national consultants—we invited them also to come. But we did not invite all of those who came in that day. They came to study the techniques of a workshop from the Department of Education and other departments.

Senator DONNELL. You say 18 or 19 Federal employees were there?

Mrs. EVANSON. I have the list here.

Senator DONNELL. As a matter of fact, Mrs. Evanson, don't you recall that it was 21 Federal employees, including those from the public service societies such as Farmers Security and Housing?

Mrs. EVANSON. That is right.

Senator DONNELL. You remember that; 21, was it not?

Mrs. EVANSON. I am not sure. More came than were invited.

Senator DONNELL. You remember Harry Becker and Miss Klem from the Children's Bureau were there?

Mrs. EVANSON.

Senator DONNELL. And Miss Eleanor Finger from the Public Health Service was there?

Mrs. EVANSON. Yes.

Senator DONNELL. Mr. Elliott Pennell was there?

Mrs. EVANSON. He was there.

Senator DONNELL. Of the Public Health Service?

Mrs. EVANSON. Yes. He was there to study the techniques, as I understand.

Senator DONNELL. He was there?

Mrs. EVANSON. Yes. But we didn't invite him to come.

Senator DONNELL. But he came?

Mrs. EVANSON. He came.

Senator DONNELL. Some men were asked and more came?

Mrs. EVANSON. Yes. We were glad to have them all.

Senator DONNELL. There was quite a delegation of Federal employees?

Mrs. EVANSON. Yes.

Senator DONNELL. How large is Jamestown?

Mrs. EVANSON. About 10,000.

Senator DONNELL. Arthur B. Price, M. D., surgeon, from the district office of the Public Health Service was there?

Mrs. EVANSON. We asked him.

Senator DONNELL. Miss Evelyn Rahm of the Public Health Service was there?

Mrs. EVANSON. Yes.

Senator DONNELL. Robert L. Prichard?

Mrs. EVANSON. Yes.

Senator DONNELL. Regional sanitary engineer of the Federal Public Housing Authority.

Mrs. EVANSON. Yes.

Senator DONNELL. Mr. Ralph Vanderworker, sanitary engineer, from the Federal Public Housing Authority, was he there?

Mrs. EVANSON. Yes.

Senator DONNELL. Was Mr. Tom G. Rathbone, assistant regional director from the Office of Vocational Rehabilitation, was he there?

Mrs. EVANSON. Yes.

Senator DONNELL. Mr. T. S. Allegrezza, associate State director from the Vocational Rehabilitation Service, was he there?

Mrs. EVANSON. He stopped in. We invited the local groups and the State offices to send a delegation. They sent Dr. Allegrezza.

Senator DONNELL. Mr. Robert D. Moe, director, Vocational Rehabilitation; was he there?

Mrs. EVANSON. Moe—I don't think I recognize the name. I don't think he was there.

Senator DONNELL. Kermit T. Piltingarud, of the Veterans' Administration, was he there?

Mrs. EVANSON. Yes.

Senator DONNELL. He is a Federal employee?

Mrs. EVANSON. That is right.

Senator DONNELL. Mark Ziegler, chief medical officer of the Federal Housing Agency, United States Department of Agriculture; was he there?

Mrs. EVANSON. He stopped there on the way to the coast. He did not remain for the conference.

Senator DONNELL. He dropped by and paid his respects for a time?

Mrs. EVANSON. Yes.

Senator DONNELL. What was he doing there?

Mrs. EVANSON. He heard of our workshop and he was interested in the techniques we used and just dropped in on his way to the coast.

Senator DONNELL. How long did he drop in, do you remember?

Mrs. EVANSON. He was there the first day.

Senator DONNELL. How many days did you run? You ran 2 days?

Mrs. EVANSON. Three days.

Senator DONNELL. September 27 to 30?

Mrs. EVANSON. Let me see. It was Friday, Saturday, and Sunday. We broke up Monday morning. Friday was just a meeting for the discussion of literature and a training school for the discussion of literature. It was not a part of the workshop.

Senator DONNELL. Mr. Kenneth Pohlmann from the Health Service Divisions of the Farmers Home Administration of the United States Department of Agriculture; was he there?

Mrs. EVANSON. He was another one who dropped in on his way to the coast and was not there for the entire conference.

Senator DONNELL. Why were these people dropping in so generously? Do you know what caused them to drop in?

Mrs. EVANSON. I haven't the faintest idea. They were interested in this workshop. It was something new. They were interested in the technique and stopped by to see if the techniques as we outlined would really work.

Senator DONNELL. What railroad is Jamestown on?

Mrs. EVANSON. The Northern Pacific.

Senator DONNELL. Dr. Lewis H. Hoyle of the regional medical office of the Housing Administration of the United States Department of Agriculture, was he there?

Mrs. EVANSON. We invited him to give us or act as a consultant on a regional basis.

Senator DONNELL. He came all right?

Mrs. EVANSON. Yes.

Senator DONNELL. Mr. Richard Cole, regional health specialist, of the United States Department of Agriculture, was he there?

Mrs. EVANSON. Yes.

Senator DONNELL. Very well. Was anybody else there from the Federal Government that you can think of at the present time?

Mrs. EVANSON. Oh, yes—Dr. Smith of the Public Health Service of North Dakota—public-health officer.

Senator DONNELL. Who else?

Mrs. EVANSON. Mrs. Ingram who is executive secretary of our State planning committee. I don't know whether or not she is with the Federal Government. We invited those interested in a workshop on health. Those from the State were called as observers. They were not allowed to participate. They were called upon to give statements from the local State or regional but were not allowed to participate in the conference. It was a farm people's conference.

Senator DONNELL. Then it was at that conference that the declaration favorable to compulsory health insurance was formulated, is that right?

Mrs. EVANSON. It was there that the declaration or the approbation of a national health program, along with a dozen other things for public-health service, were discussed. We wanted to bring electricity to our rural areas so that we might bring in sanitation. We demanded more hospitals; find ways and means of getting more doctors. We took up a dozen different phases of the health program.

Senator DONNELL. Among those dozen was compulsory health insurance and you favored that?

Mrs. EVANSON. No. It is very amusing. We had quite a controversy the last day over accepting our reports. We accepted compulsory health insurance, but we had some controversy as to which was the most important, and we stated that the most important immediate problem was a cooperative community hospital and health clinics.

Senator DONNELL. But you say you did formulate an expression favorable to compulsory health insurance?

Mrs. EVANSON. Yes.

Senator DONNELL. At the health workshop which had all these Federal employees that dropped in?

Mrs. EVANSON. That is right.

Senator DONNELL. Go ahead with your statement.

Mrs. EVANSON. I am Mrs. Jerome Evanson, of Jamestown, N. Dak., director of education for the North Dakota Farmers Union. As a rural school teacher and later a farm wife for 20 years, a mother of three children raised on the farm, I feel I can speak for the farm mothers. As director of education for the North Dakota Farmers Union I speak for over 32,000 farm families, and as a representative of the national department of education I speak for 200,000 farm families in 26 States. I speak out of my experiences on the land and the experiences of my neighbors.

I do not have to tell you that the greatest need in rural areas today is health services, doctors, rural hospitals, diagnostic services, and finding ways of paying for medical care. You know the shocking figures in the rejection of rural boys for the armed services. You have been given the rates of needless deaths in rural areas from preventable diseases—of needlessly high maternal and infant death dates—the higher death rates in all age groups. We, the farm people, are becoming increasingly concerned when we note the apathy and indifference of the Nation as a whole to the health conditions in rural areas, and we are also concerned with the trend toward more concentration of hospital and health facilities in population centers while rural people remain without services and our rural mothers and babies continue to die because of lack of proper care, our old people suffer from inadequate care, and entire rural areas are exposed to contagious diseases because public health services with sanitation programs and prevention programs are not considered necessary or feasible in rural areas.

Yes; we are becoming increasingly concerned when we, as a rural group meeting together, face a tirade of accusations hurled at us by the American Medical Association, demanding that Congress spend great sums of money to investigate these rural people whose only crime is that we dared to discuss the health situation in rural areas and discuss ways and means of working together to obtain a small share of the facilities and health services that have been denied us. The false statements and misinformation as reported by the press brought to the congressional investigating committee by the representative of the North Dakota Medical Association without an opportunity to answer those accusations have made us wonder just who won the war—democracy or the Gestapo. We deeply resent the efforts of the medical association to restrict and prevent discussion of the health needs of rural people by Gestapo methods of intimidation, and I wish to inform this group that we intend to have another health workshop, that we are making a request for consultants on the various phases of the health program, and we want to know if these consultants will be available for specific information as specialists in their respective fields without being crucified by an American Medical Association sponsored witch hunt. In the name of goodness we tell you that all we want is an opportunity for our rural people and their families to get the care that should be the right of every citizen of a country that boasts the finest medical facilities and personnel in the entire world. We need this consultant service in the development of a rural health program, and we feel that it is equally important that these specialists spend more time out in the rural areas that they may obtain first-hand information as to our needs and so better serve these neglected areas in this country. In my State where there are still 41 counties out of 53 and 81.5 percent of the people who do not have local health services, our Government spends huge sums each year to keep our cattle healthy, to prevent disease in poultry and in plants. We ask the same consideration for our children, with this exception—that we want to pay our way. This Government-sponsored program has not cheapened the care given to our livestock—neither do we intend that they shall cheapen medical care. We want to spread the cost and make health services available to all. The recent congressional investigation is indeed an indictment of the American Medical Association and its tactics to prevent a constructive program of rural health. Their idea of a rural health program is to provide bigger and better health centers in the large population centers, and so rural mothers continue to die needlessly, preventable diseases are not prevented, children are weakened physically by the frequent repetition of contagious diseases, and farmers in the most hazardous of all occupations are too often hopelessly crippled because of lack of proper care.

Yes; we are increasingly concerned by the attitude of the American Medical Association and the indifference of the Nation as a whole on a problem that so vitally affects every citizen. If we are to continue to furnish men and women for the labor markets of the industrial centers and for military service, then the entire Nation must be made aware of the present terrific waste of human resources and give earnest consideration to the health needs of these same people.

We worked hard for the Hill-Burton bill, now Public Law 725, which was to provide funds for the establishment of hospitals in areas of greatest need. It was considered one of the first steps in a program to improve health standards in rural areas. Restrictive clauses have made this act a farce as far as areas of greatest need are concerned. In the first place, matching funds are provided on a ratio of one-third of the cost carried by the Federal Government and two-thirds of the cost carried by local people, thus making it prohibitive in rural areas standing in greatest need. Secondly, no rural community is eligible for Federal funds that cannot guarantee maintenance of the hospital, making it impossible for low-income areas to avail themselves of Federal funds. The only communities eligible will be those communities with already established health facilities that can guarantee an income for maintenance. However, there is one way to make Public Law 725 workable in areas that today cannot support a hospital and that is by enacting the national health insurance program, S. 1320. It would provide medical care to every citizen regardless of income, and so guarantee maintenance for every rural hospital.

Let us assume that these Federal funds under Public Law 725 were available without any restrictive clauses and hospitals were built to provide services within easy distance of all farm families, they would still be out of reach of most of our people so long as medical and hospital care is made prohibitive because of excessive cost. Voluntary insurance can never bridge the gap since coverage is not complete and the cost is not within reach of the average pocketbook. Too many people today who are within reach of facilities are deprived of them because of their inability to pay for these services. This was brought very forcibly to our attention during the depression of the thirties when a group of rural women discussing our health needs were reprimanded by the State health officer because we insisted "on discussing our health problems instead of our blessings," and the health officer proceeded to tell us that we in North Dakota should be eternally grateful for the overabundance of hospital beds in our State, citing that only 65 percent of our hospital beds were in use at any time. To us abundance does not mean much when we cannot obtain that abundance. We could not rejoice over the fact that there were so many empty beds when we knew they were empty because we could not afford hospital care. Today, with good crops and good prices, hospital beds are at a premium, and practically all the hospitals are expanding their facilities and many new hospitals are under construction. But we haven't forgotten the depression years and the vacant hospital beds, the people dangerously ill being turned away, not because there were no rooms available but because they could not guarantee payment for hospital care. A mother of a large family seriously ill with pneumonia kept out on the street in the winter cold for hours because her husband could not bring her into the hospital until he could guarantee payment for hospital care. A stranger to them, hearing of their plight, guaranteed the bill to save the mother from certain death. We cannot forget the fathers pleading with a doctor to come out in the country to treat the mother or child too ill to be moved and being told that the doctor would make the trip only if there was the stipulated cash on hand when he arrived at the home—and this at a time when cash was as scarce as hen's teeth. Out of these experiences we have vowed that health care must no longer be a purchasable commodity available only to the fortunate few—and they are few—who can meet castastrophic illness without losing their life's savings and their homes in the process of purchasing hospital and health services for their loved ones.

In a questionnaire sent out to rural communities in the State survey of my home State, where 21 counties do not have hospital facilities and 6 counties have neither doctor nor hospital, the following comments on health services were made—

1. Cases for hospitalization must go either to Miles City (by train) 225 miles distant, or to Dickenson 80 miles distant (over poor roads), or to Aberdeen 230 miles distant (by rail).
2. No medical care in our immediate vicinity. Must travel 20 or 30 miles to get to a doctor. When roads are blocked, babies are born without the aid of a physician. Physicians do not find time to come out into the country.
3. Many people have hesitated to call a doctor because of the large fee for his trip.
4. School attendance bad at times due to preventable diseases.
5. Water should be tested. Conditions could become serious. Surface water gets into wells.

6. No sewer or water system. All outside toilets—wells not too far away.

7. There is only one small hospital (nursing home) in our county. Many people are forced to go 30 or 45 miles to a doctor.

8. Very decided lack of dental care, serious lack of every type of health facility, health care, and personnel—doctors, nurses, dentists, even practical trained home nurses.

9. No drug store closer than 15 to 17 miles. Urgent need for a sewage system because of numerous sloughs being used for private drainage.

At the American association conference in Chicago in January the director of rural health services stated that adequate medical care can be made available to all if they are willing to pay for medical care instead of spending their money for cars and luxuries. We were not aware that in this day and age a car was considered a luxury to the farmer. Would he have us go back to the horse and buggy? To farmers, the greater percent of whom have no electricity, no running water, no central heating system—things that their city cousins have taken for granted for years—these would be luxuries, but only a very small percent of our rural people can afford such luxuries. Most of us in rural areas have insanitary outdoor toilets, questionable water supply, crowded, ill-heated, ill-lighted homes—yet we are accused of spending our money for luxuries. One-third of all the homes lost in Wisconsin are lost because of excessive medical bills. I suppose home ownership is a luxury too, that we should not indulge in. This spokesman for the medical association is the same doctor who stated:

> He (the marginal farmer) is presented as above the indigent but below the level of those able to form a prepayment group. He should be classed as medically indigent and cared for by taxation, but this term gives offense and must not be used—which makes the situation very difficult.

By the way, at this American Medical Association conference the term "medically indigent" was defined to include 85 percent of the population of the United States. I return to the quote—

> He (the farmer) needs help, he wants help, but cannot pay for it. He refuses what he considers charity at the hands of the taxpayer, but complains of hardships and inequities when he fails to receive it.

Again we wish to state emphatically that we do not want and will not accept medical care in the name of charity or relief, with the means test thrown in for good measure. We had hoped that our Congress, who should serve the people, still believed in the dignity of human personality. We want a plan whereby we can pay our own way, and we want a plan that will assure to us and our children a reasonable chance for good health. Our desires cannot be met by the humiliating charity offered in the Taft bill. They cannot be met by the inadequate coverage and prohibitive fees of voluntary health plans. Prevention of sickness, which is a fundamental of a good health program, is conspicuously absent from the voluntary prepayment plans since they function only when the person is ill. Only a compulsory health plan as embodied in the Wagner-Murray-Dingell bill can give us assurance of hospital and health services—and the democratic right and privilege of paying for these services. Since compulsion is so offensive to the medical association, we suggest that they set an example by eliminating compulsion that figures so prominently in their own profession. The medical association is terribly concerned about the cost of a national insurance program. It reminds me of the town that could not spend $150 for immunization against diphtheria. It purchased park benches instead. During the succeeding 2 years, however, it cost the city $1,500 for hospitalization of diphtheria cases—penny-wise and pound-foolish.

Compulsory health insurance is an investment in good health and good citizenship. It is an investment in human resources that produce our Nation's wealth. It is a bulwark against waste of these resources. It brings security to all people regardless of their financial rating. Disease is no respecter of persons, and the wealthy cannot be secure from disease as long as lower-income groups cannot afford proper health care. Health insurance is not socialized medicine. The health insurance principle works in the same way as unemployment insurance—social security—which has certainly not socialized our Government or caused the Communists to seize control of the Government as predicted by the same group that has a stake in our illness rather than our good health.

The greatest need in rural America today is the small rural hospital. This rural medical and nursing center is the basic unit in the entire rural health plan. The policy therefore should not be to build many new large hospitals and crowd hospital patients into the large centers but rather to erect a large number of small hospitals in rural districts. This can only be done when these hospitals and the doctors are assured an adequate income. Voluntary prepayment plans cannot guarantee incomes; only compulsory prepaid insurance can do that. Therefore, we of the Farmers Union will continue our efforts to make the Wagner-Murray-Dingell bill the law of the land.

I speak not for the farmer typified in Millet's painting "The Man with the Hoe"—bowed by the weight of centuries, accepting hard toil and a meager, starved existence—the while he mutters "Thy will be done." I represent the awakened farmer—the organized farmer—who, with shoulders squared to accept his share of the responsibility, looking up and beyond his green acres, with a deep conviction prays "Thy will be done on earth as it is in Heaven." He has seen wars, depressions, drought, and epidemics—all needless calamities—destroy or maim his loved ones and his acres. Needless calamities, yes, and for his people and for the sake of humanity he is doing something about it, the while he prays that he may make his contribution toward "Thy kingdom come on earth."

May we again remind you that people move whether institutions do or not—we desire the cooperation of the medical association in making health services and the gains of medical science available to our rural people, and we shall continue to move forward on a national health plan with or without their cooperation.

In conclusion, we wish to thank the North Dakota Medical Association and the American Medical Association for the wide publicity given our efforts in North Dakota. We had no idea our workshop was so important or that the work we did there was of such national significance. We are grateful to them for focusing national attention upon our humble efforts. We are proud to be singled out as a group that does something about their problems and are identified as supporters of Senator Murray and his cosponsors in their courageous fight to make health services available to all of our people. We appeal to this committee to do everything in its power to bring about a national health-insurance plan as embodied in S. 1320.

Senator DONNELL. Mrs. Evanson, you are director of education of the North Dakota Farmers Union?

Mrs. EVANSON. That is right.

Senator DONNELL. Are you employed also by the National Farmers Union?

Mrs. EVANSON. No; I am not, except Mrs. Edwards has been quite ill and she has asked me, the State director, to represent her.

Senator DONNELL. The Mrs. Edwards to whom you refer, is she not a member of the Cooperative Health Federation of America?

Mrs. EVANSON. She is, I believe, a member of one of the advisory councils, if I am not mistaken.

Senator DONNELL. You are familiar with that?

Mrs. EVANSON. Yes.

Senator DONNELL. Did you attend a conference over at Two Harbors, Minn., from August 15 to 18, 1946?

Mrs. EVANSON. Yes.

Senator DONNELL. You know about the fact that the Labor Medical Agency under the direction of the Cooperative Health Federation of America was authorized at that meeting?

Mrs. EVANSON. That is right.

Senator DONNELL. Did you participate in that organization?

Mrs. EVANSON. Yes; I did.

Senator DONNELL. Are you a member of the Cooperative Health Federation of America?

Mrs. EVANSON. As National Farmers Union is a member. We in North Dakota have not applied since it was not clear as yet whether the National represented all of us or whether the States should take up representation. We will be delighted to take up membership at such time.

Senator DONNELL. You are in thorough sympathy with the Cooperative Health Federation of America as announced by Harry Becker on September 12, 1946, to have been incorporated, that is?

Mrs. EVANSON. Yes, Senator.

Senator DONNELL. Mr. Becker is of the Children's Bureau of the United States Government?

Mrs. EVANSON. That is right.

Senator DONNELL. Now, do you know that among the incorporators of the Cooperative Health Federation of America is Mr. James Carey, of the National CIO?

Mrs. EVANSON. Yes.

Senator DONNELL. Mr. Nelson Cruikshank, of the American Federation of Labor?

Mrs. EVANSON. Yes.

Senator DONNELL. Gladys Talbot Edwards, of the Farmers Union? That is the lady you referred to?

Mrs. EVANSON. Yes.

Senator DONNELL. And Dr. Dean Clark, of the United States Public Health Service?

Mrs. EVANSON. That is right.

Senator DONNELL. They are among the incorporators of this Cooperative Health Federation of America?

Mrs. EVANSON. I don't know whether they are the incorporators. I understand that Mrs. Edwards was to be on the advisory committee in incorporating. She might be.

Senator DONNELL. You are not saying she isn't. You don't know whether the others are incorporators? How about Cruikshank and Clark?

Mrs. EVANSON. I rather think they are.

Senator DONNELL. You are not certain?

Mrs. EVANSON. No, Senator.

Senator DONNELL. They hold official capacities?

Mrs. EVANSON. Yes.

Senator DONNELL. You are an employee of the North Dakota Farmers Union?

Mrs. EVANSON. Yes, sir.

Senator DONNELL. You have been employed by it since 1940, have you not?

Mrs. EVANSON. Yes, sir.

Senator DONNELL. You have devoted all of your time to your employment?

Mrs. EVANSON. Full time.

Senator DONNELL. You are appearing today on behalf of the National Farmers Union and at the same time you are employed full time by the North Dakota Farmers Union and are appearing as an employee of that organization?

Mrs. EVANSON. That is right.

Senator DONNELL. Do you have any hail insurance out in North Dakota?

Mrs. EVANSON. Yes, sir.

Senator DONNELL. I will ask whether or not North Dakota tried to have compulsory hail insurance?

Mrs. EVANSON. We did and it worked very well. We were able to bring the hail insurance down to 8 cents an acre and it was paid with the taxes and was very successful. Would you like me to tell you the story of it?

Senator DONNELL. I was going to ask how long did this hail insurance exist as a compulsory hail insurance?

Mrs. EVANSON. Quite some time. I just can't remember when it was enacted into law but when we were on the farm we paid out hail insurance through taxes—at the time we were on our own farm. I can't tell you just how long it is.

Senator DONNELL. It was several years?

Mrs. EVANSON. Oh, yes.

Senator DONNELL. When compulsory hail insurance was in effect was it satisfactory?

Mrs. EVANSON. Very satisfactory.

Senator DONNELL. Very satisfactory?

Mrs. EVANSON. That is right.

Senator DONNELL. Well, the legislature, however, changed the law from compulsory hail insurance to voluntary?

Mrs. EVANSON. In order to give you the true story, I might tell you that the bankers and the private insurance companies put on a terrific lobby at the State legislature at that time. They said in effect: "You folks know that compulsory hail insurance is good. You have proven it to be a very good law, but anything compulsory is very un-American, very undemocratic and is a wedge for socialism. So we are asking you just to change that from compulsory to voluntary. You people have accepted it and it is very satisfactory. You won't have to worry about it." So the people in the legislature changed the law from compulsory to voluntary, and immediately the people who were not in the hail belt said, "What is the use of paying for it; it does not come in the taxes." They did not have to meet a deadline. Now voluntary insurance is 87 cents an acre whereas under compulsory insurance it had been 8 cents an acre. And the people who need it, those in the hail belt, are completely defeated. They cannot afford hail insurance at 87 cents an acre.

Senator DONNELL. The point I was getting at—North Dakota did for several years try compulsory hail insurance?

Mrs. EVANSON. Yes.

Senator DONNELL. And for whatever reason the legislature deemed proper, regardless of what caused it, the fact remains that the legislature changed the hail insurance in North Dakota from compulsory to voluntary, is that right?

Mrs. EVANSON. That is right.

Senator DONNELL. You think that was unwise?

Mrs. EVANSON. Very definitely.

Senator DONNELL. But your legislature hasn't thus far agreed with you?

Mrs. EVANSON. It has not been taken up in the legislature because the farm people are not now in control of the legislature.

Senator DONNELL. At any rate, the legislature has not changed it back again to compulsory?

Mrs. EVANSON. We intend to do something about it.

Senator DONNELL. I understand. But I say the legislature has left it at its face value and has not changed it back to compulsory?

Mrs. EVANSON. That is right.

Senator DONNELL. It has been a number of years since it was changed back to voluntary?

Mrs. EVANSON. Yes, Senator.

Senator DONNELL. Do you know how many years it has been running as voluntary instead of compulsory?

Mrs. EVANSON. I can't say.

Senator DONNELL. You know about how many?

Mrs. EVANSON. I couldn't say at all.

Senator DONNELL. Ten years?

Mrs. EVANSON. It was in effect when we left the farm in Grand Forks County; that was in '32. Since then I don't know because since that time we have lived on a rented farm and had no reason to know about it.

Senator DONNELL. In 1932 voluntary was in effect?

Mrs. EVANSON. Compulsory.

Senator DONNELL. Now, about how long after you left the farm in 1932 was it changed over from compulsory to voluntary?

Mrs. EVANSON. That I don't know because I was not interested in it any longer since we did not pay the insurance premium.

Senator DONNELL. To the best of your knowledge has it been less than 5 years since it has been back to voluntary?

Mrs. EVANSON. More than that.

Senator DONNELL. Possibly 10 years?

Mrs. EVANSON. Possibly.

Senator DONNELL. You left the Grand Forks farm 15 years ago?

Mrs. EVANS. In '32.

Senator DONNELL. That would be 15 years ago?

Mrs. EVANSON. Yes.

Senator DONNELL. You know that some time after that, and you think certainly more than 5 years ago, it was changed from compulsory hail insurance to voluntary hail insurance?

Mrs. EVANSON. That is right.

Senator DONNELL. The legislature has left it for certainly 5 years and maybe more as a voluntary rather than a compulsory hail insurance, is that right?

Mrs. EVANSON. Not because——

Senator DONNELL. Is that right?

Mrs. EVANSON. Not because the farmers wanted it. They lost control in the legislature.

Senator DONNELL. At any rate it has been left for more than 5 years as a voluntary and not compulsory hail insurance?

Mrs. EVANSON. That is right.

Senator DONNELL. All right. Now, this group that came into Jamestown at this workshop, some 20 or thereabouts, of Federal employees that you had, did they bring along with them kits or different collections of documents and publications to show how compulsory health insurance would work and distribute data among the people that were present at the conference?

Mrs. EVANSON. No, sir; that is a false statement. I directed the conference. I sent to the CIO for material. I sent to the A. F. of L.; I sent to the National Farmers Union; I sent to the Public Health Service; I collected the material and put it into kits and distributed them as the Farmers Union kit. It was not distributed by Public Health officials.

Senator DONNELL. Did the Public Health officials assist you in getting the data you put into the kit?

Mrs. EVANSON. No. I wrote to them asking for material that would be good for the health conference kits. I told them that one of the things we wanted to do was to assemble data, so that the people who came could take the material home and study it. I got material also from the CIO and the A. F. of L., and the National Farmers Union—wherever I could get material on health. I gathered it together and I made up the kits myself. That is definitely a false statement that was made at that time.

Senator DONNELL. You wrote a letter here to Washington from out in North Dakota telling the Government authorities here that you wanted to make up these kits and to please send on data and booklets—anything that would be appropriate to put in those kits, is that right?

Mrs. EVANSON. That is right.

Senator DONNELL. And they sent those things to you?

Mrs. EVANSON. They sent material from the Government. The CIO and the A. F. of L. sent material direct from their organizations. The best material that we got was from the War Department.

Senator DONNELL. Did the Government send you any committee reports or subcommittee reports here from the Senate as a part of the argument in favor of compulsory health insurance in response to your request for data?

Mrs. EVANSON. I can't say. I don't remember any. There may have been. We got a wealth of material.

Senator DONNELL. You got a wealth of material from the Government?

Mrs. EVANSON. From all sources.

Senator DONNELL. I mean from the Government?

Mrs. EVANSON. I can't say definitely that we got any testimony.

Senator DONNELL. I didn't mean testimony. I meant pamphlets containing any reports of committees or subcommittees of the Senate?

Mrs. EVANSON. No; I don't remember that. There may have been; I don't remember it.

Senator DONNELL. Did you receive anything entitled "A Medical Care Insurance" from the Government to go into that kit?

Mrs. EVANSON. I don't remember. I would not be able to say. I received so many things it is difficult to remember any one specifically. I would be very glad to look that up.

Senator DONNELL. I wonder if you would be kind enough to make that list and send it to the clerk of this committee—everything that came from the United States Government, to go into these kits. Would you be so kind as to do that?

Mrs. EVANSON. I shall be glad to if my secretary has that list and if there is a kit left there.

Senator DONNELL. Will you do the best you can?

Mrs. EVANSON. I will try.

(Subsequently the material referred to was filed with the committee.)

Senator DONNELL. I wanted to ask just a very few more questions. In the first place, I think you said something about doctors not giving service until there is cash on the barrel head or words to that effect. Do you know of many instances to that effect?

Mrs. EVANSON. Many instances.

Senator DONNELL. How many instances do you know of?

Mrs. EVANSON. Well, the ladies have told me so many instances, and the embarrassing thing about it all is that we have party lines out in the country and they were not only humiliated by the doctor but by all of the neighbors who are always considerate enough to listen in on all conversations on the party line.

Senator DONNELL. Might I read to you a little of your testimony before the Committee on Education and Labor, pages 1250 and 1251, and ask you if that is true? [Reading:]

> Mrs. EVANSON. I have. I have seen doctors turn down people in our rural areas in my home town, and they have stayed out on the sidewalk, serious cases, and refused to accept them as their patients until they were guaranteed their payment, and the people were aroused almost to riot intensity, demanding that that doctor take care of his patients.
>
> Senator DONNELL. You have seen that yourself?
>
> Mrs. EVANSON. Yes; I have seen it.
>
> Senator DONNELL. And you know who the particular doctors are that you refer to?
>
> Mrs. EVANSON. Yes.
>
> Senator DONNELL. Are they in Jamestown, N. Dak.?
>
> Mrs. EVANSON. No.
>
> Senator DONNELL. What town are they in?
>
> Mrs. EVANSON. In my home town.
>
> Senator DONNELL. What town is that?

Mrs. Evanson. It is Northwood, N. Dak. But it is not the doctor that is there now.

Senator Donnell. Is the doctor that you are referring to living or dead?

Mrs. Evanson. No; I think he is dead now.

Senator Donnell. You think he is dead?

Mrs. Evanson. He moved away; he did lose prestige.

Senator Donnell. Did you ever know of any other doctor beside that one?

Mrs. Evanson. Yes.

Senator Donnell. That was guilty of any such conduct as that?

Mrs. Evanson. Yes; I heard of it but I did not see it. But I have heard of the very same situation right in the city of Jamestown, and I understand that groups of people got together and demanded that—they had to get a guaranty from the county to pay that bill before he would accept the patient.

Senator Donnell. That is just one doctor in Jamestown; is that right?

Mrs. Evanson. That is what I have understood.

Senator Donnell. You do not personally know about it?

Mrs. Evanson. No.

Senator Donnell. That is just hearsay; is that right?

Mrs. Evanson. It is not hearsay, because it was told to me by people who were interested in it and had to see that the county took care of it.

Senator Donnell. But you yourself know only of it from what some of those people told you?

Mrs. Evanson. Of that instance.

Senator Donnell. You do not know the doctor's side of it?

Mrs. Evanson. No.

Senator Donnell. You never talked to him about it?

Mrs. Evanson. No; I have not.

Senator Donnell. Are those the only two doctors that you personally know of who have been guilty of this kind of unkind conduct?

Mrs. Evanson. No; in our discussions of health out in the rural areas, I have heard enough stories to make me sick.

Senator Donnell. You do not——

Mrs. Evanson. Sick at heart and sick to my stomach for the things that have been done.

Senator Donnell. You feel that the medical profession is in many instances guilty of very reprehensible conduct; is that your thought?

Mrs. Evanson. Yes, indeed.

Senator Donnell. As you have indicated, you think there is this clique that places dollars above health?

Mrs. Evanson. I want to say this——

Senator Donnell. Just a minute. Is that right?

Mrs. Evanson. Yes.

Senator Donnell. All right.

Mrs. Evanson. I want to say this, that I will admit that many doctors have had to do a lot of charitable work and in North Dakota during the drought I think they came to the limit of their endurance, too, but nevertheless that was the case.

Senator Donnell. Generally speaking, aside from the particular instances that you have referred to, and that you have heard of, generally speaking, did you not think, Mrs. Evanson, that the medical profession is composed of high-minded, generous, and honorable people? Is not that true?

Mrs. Evanson. Yes, indeed; and I think they are too generous. They give too much for nothing.

Senator Donnell. You think they give too much for nothing?

Mrs. Evanson. And I do not think we should expect it, and we do not want charity. We want some way of paying for it.

Is that testimony correct and true that I have read here?

Mrs. Evanson. Yes.

Senator Donnell. Is there any further information you have other than along that line?

Mrs. Evanson. Except the information I have from a fellow worker who is the man who guaranteed the bill of this woman who was out on the street with pneumonia, and I can't say for sure but he said she was out a number of hours.

Senator DONNELL. That is in North Dakota?

Mrs. EVANSON. That happened in Bismarck.

Senator DONNELL. That is one of these you referred to in your statement?

Mrs. EVANSON. Yes.

Senator DONNELL. But, generally speaking, as indicated here, do you think, Mrs. Evanson, as you did here, that the medical profession is composed of high-minded, generous and honorable people; is that true?

Mrs. EVANSON. Yes.

Senator DONNELL. Even too generous; they give too much for nothing?

Mrs. EVANSON. That is right.

Senator DONNELL. Thank you Mrs. Evanson. We appreciate your coming here.

At this time I offer into the record this excerpt from the American Policy Platform of American Veterans Committee as set forth in a speech by the Honorable James E. Murray, of Montana, in the Senate of the United States on July 3, 1946. This excerpt reads as follows:

> We demand the exposure by vigorous public campaign of each Senator and Congressman who voted to destroy price control by crippling amendments.

I will ask that the entire American policy platform of American Veterans Committee, from which I have read this excerpt be placed in the record, along with a copy of the constitution of the American Veterans Committee. I will ask they be incorporated in the record.

(The American policy platform of the American Veterans Committee and its constitution follow:)

AMERICAN POLICY PLATFORM OF AMERICAN VETERANS COMMITTEE

(Speech of Hon. James E. Murray, of Montana, in the Senate of the United States, July 3, 1946)

Mr. MURRAY. Mr. President, I ask unanimous consent to have printed in the Record the domestic policy platform adopted by the American Veterans Committee, AVC, at Des Moines, Iowa, June 14 to 16.

This platform was drafted by veterans of this war who are keenly interested in the destiny of America. I believe that the platform is a remarkable achievement. It should be studied carefully by Members of Congress as an important indication of the type of national program which young America wants.

The platform was adopted at the first national convention of AVC under circumstances which were variously described as "democracy in action" and "an inspiring miracle." The delegates were deadly serious. They had no time for capering. They were urgently interested in adopting policy platforms which would express their feeling that a program of progressive legislative action is necessary to save America from another boom-and-bust cycle.

AVC stands for a liberal program. Their progressivism follows along the line of the great precedent set by the late President Franklin D. Roosevelt. They want action. They feel that the fate of their own generation, as well as that of their children, hangs in the balance. They are anxious that we hear their pleas for democratic action on the problems facing us all.

They have attacked specific problems with courage and foresight. To mention but a few of the stands they have taken on matters of immediate interest, they want a realistic housing program, a strong democratic labor movement, the development of our river valleys, a vital price-control program, an honest opposition to discrimination, aid to small business, a Federal health program, and a tax program based upon ability to pay.

I personally am deeply moved by this platform because it includes many of the major legislative goals for which I have worked during my many years in Congress. I want to commend the members of the American Veterans Committee (AVC) for their unselfish interest in the welfare of all America and wish them success in creating a reawakened and revitalized public opinion among the veterans of this war.

There being no objection, the platform was ordered to be printed in the Record, as follows:

PLATFORM PASSED BY FIRST CONSTITUTIONAL CONVENTION, AMERICAN VETERANS COMMITTEE, INC., DES MOINES, IOWA, JUNE 15, 1946

Domestic affairs

As citizens and veterans our greatest stake is in a democratic and prosperous America and a stable world. As all men, our primary needs are peace, jobs, and freedom. We have learned at high cost that the "four freedoms" are inseparable; that without freedom from want and freedom from fear we cannot enjoy nor truly know freedom of religion and freedom of speech. We have learned that without security there is only the freedom to suffer or perish. Accordingly we turn our attention to those domestic, economic, political, and social problems which must be solved as a part of the task of winning the peace. We are confident that with our abundant resources, our manpower and skill, and our basically sound democratic system we can solve these problems. This is our program for action.

I. Housing

1. We demand that the wartime governmental controls—priorities, subsidies, price controls—now again be utilized to give us homes in which to live. Particularly, we demand that building materials be channeled into low-cost residential construction.
2. Where private builders are unable or unwilling to build low-cost homes, government must build them. Until the emergency has been dealt with, unessential and deferrable construction, like racetracks and office buildings, should be denied building permits.
3. We demand that the powers granted the National Housing Expediter be exercised immediately to carry out the enacted legislative housing program so that at least 50 percent of the 2,700,000 housing units be permanent low-cost rental units. We urge that representatives of World War II veterans' groups active in housing be put on mayors' and OPA housing committees; and that unoccupied usable housing be made available to veterans who now have no homes.
4. Finally, we urge immediate enactment of the present provisions of the long-term Wagner-Ellender-Taft bill.

II. Labor

1. We favor all measures by business, employees' organizations, and Government necessary to insure full and fair employment.
2. We urge amendments to the Federal Fair Labor Standards Act to provide a minimum wage of 75 cents an hour and of State laws to provide an equivalent minimum wage for employees not subject to Federal legislation.
3. We favor the principle of a guaranteed annual wage and immediate steps to bring it about as soon as practicable.
4. We favor the continuation of the maximum workweek of 40 hours for all workers with time and a half for all hours over 40 and double time for the seventh day.
5. We recommend a permanent Federal Employment Service.
6. We urge uniform Federal unemployment compensation at a minimum rate of $25 for 26 weeks for unemployment of all kinds, including time lost due to labor disputes, and extension of social-security provisions to cover all persons.
7. We urge continuance and improvement of our safeguards against child labor.
8. A strong democratic labor union movement is one of the most effective forces for political and economic democracy in the United States. We therefore support the right of all organized labor to unionize any or all workers anywhere in the United States. We recommend to union leadership recognition of its responsibility not alone to union membership but to the entire public as well. We recommend that such leadership exercise its responsibility by promoting efficiency and an ever increasing production of goods to provide an adequate standard of living for all.

9. We favor broadening and strengthening collective bargaining. We oppose any form of compulsory arbitration, the use of armed forces in labor disputes, and any procedures crippling the laws protecting labor against injunctions. Labor's right to strike must be maintained.

III. Agriculture and natural resources

1. The welfare of the agricultural population depends primarily upon full employment and a rising level of consumption for all elements of the population. In this respect the basic problems confronting agriculture are identical to those of labor, and we call upon both groups to support each other fully for their mutual benefit. American democracy is deeply rooted in the historic family type farm unit as contrasted to the growing corporate type of land ownership and farm operation. We favor the improvement and stabilization of tenure arrangements giving special emphasis to programs designed to encourage owner operation of family type farm units.

2. To promote these ends we urge that appraisal of land values for tax purposes and for mortgage loans to be commensurate with expected incomes, that utmost support be given to cooperative marketing, purchasing, and service facilities, soil- and water-conservation programs, land-use planning, reforestation, rural electrification, farm housing, and health and education.

3. We favor a full production policy for agriculture within the limits of good soil use. In consideration of farmers' full production programs, we favor direct income payments to agriculture when necessary in preference to support of market prices which injure the consumer.

4. Where necessary to enable farmers to get needed machinery and repairs immediately in order to produce critically needed food requirements, we urge Government seizure and operation of closed farm equipment factories.

5. As veterans, we recognize that the greatest strength of our Nation is in its peoples, its resources, its rivers, its lands, and what lies beneath the land. Therefore we will support the creation of valley authorities modeled on the TVA in such areas as the Missouri, the Arkansas, the Columbia River, and Central Valley (Calif.) watersheds, and the creation of a Great Lakes-St. Lawrence seaway and corelated power developments, in this way opening up new frontiers of science, agriculture, and industry.

IV. Price and rent control

1. Legislative or executive action weakening the price and rent line now being defended must be condemned. We favor a strong policy of price and rent control with adequate appropriations for its enforcement and the release of any commodity from control only when its supply and that of related commodities is sufficient so that the price will not rise measurably when control is lifted.

2. The practice of using wage or other cost increases as a basis for price increases where added costs may be absorbed within established industry profit standards as now defined and economies of mass production, are unjustified.

3. We urge that the price and rent-control lines be further safeguarded by the establishment of commercial rent ceilings. We favor the extension of priority and allocation regulations to force production of low-cost items.

4. We urge that the United States return to a system of rationing of essential commodities such as food, clothing, and building materials where necessary to fulfill commitments to starving nations of the world and provide essential commodities for all citizens and veterans of the United States.

5. We recognize that no issue is more important to veterans and the American people than effective price and rent control. Therefore we condemn the action of the Senate and the House of Representatives in emasculating the OPA. The proposed legislation strikes a crucial blow against our entire stabilization program. It will lead to ruinous inflation followed by a period of unemployment, bankruptcy, and hardship at home and abroad. It represents a direct denial, in face of overwhelming evidence, of our objective to achieve and maintain full employment. We urge President Truman to veto the bills offered by either House of Congress.

6. We demand the exposure by vigorous public campaign of each Senator and Congressman who voted to destroy price control by crippling amendments.

7. We instruct our national leadership to consult immediately with all national organizations for the purpose of taking militant steps on a Nation-wide coordinated scale to rescue OPA from inflationary forces. Such steps to include:

(1) Simultaneous Nation-wide demonstrations;
(2) buyers strikes;

(3) veteran, consumer, business, and labor delegations to Congress;

(4) any other measures that are necessary to convince an indifferent Congress that the people insist upon having a strong, adequately financed and staffed OPA.

V. Industry

1. Business management not only has a responsibility to the owners of business but it also has a social responsibility to labor and the public. It must constantly attempt to provide full and increasing production, full employment and greater business efficiency. When business management falls down on this social responsibility proposals and action are bound to ensue which it then claims are inimical to business.

2. We believe that American democracy requires efficient and prosperous small business. We therefore recommend a liberal credit system for small businessmen, legislation to provide them with adequate market research and scientific and technological service, and the granting to them of preference over big business in obtaining surplus war materials and surplus plant facilities.

3. We consider the antitrust laws to be basic American policy. We therefore oppose the removal of any industry from the operations of these laws and urge their effective enforcement. In those industries where the enforcement of the antitrust laws do not insure adequate competition and where artifically high prices may be maintained, production limited, and opportunities for employment destroyed we favor effective Government control or ownership.

4. We oppose restrictive legislation on legitimate cooperative societies.

5. We urge the elimination of regional discrimination in freight-rate differentials.

6. We recommend the retention or reestablishment of production controls until normal demand and supply relationships exist.

VI. Health

1. The health of every citizen is the concern of the Nation. We therefore favor a comprehensive national health program to include hospital planning and construciton, Federal aid for the establishment of community-wide health service, compulsory health insurance to provide adequate personal medical care for all citizens, extension of social security protection as it relates to health, particularly disability compensation, and establishment of an adequate mental health program.

2. Industrial accidents and occupational diseases represent continuous national peril and a drain on manpower. Accordingly, we urge adequate legislation, particularly in the several States, adequate research and the appropriation of enough funds by the responsible governmental authorities to obtain sufficient inspections and to promote accident prevention campaigns to reduce such casualties.

VII. Education

1. The present educational system presents serious inadequacies, particularly regarding discrimination, equal opportunity, and adequate compensation for teachers.

2. We demand national legislation to bring about improved educational facilities with equal opportunity and facilities for all. We favor Federal aid for the public-school systems of the country on a per capita and not on a State matching basis, with safeguards to prevent Federal control of what is taught.

3. Any discrimination in school entrance requirements due to race, creed, color, or national origin must be eliminated. We favor the repeal of tax exemptions to schools engaging in such discrimination; and we are opposed to segregation in schools.

4. We favor the establishment of free college and professional schools, admission to which shall be based on merit only.

5. To enlarge the educational opportunities of veterans we favor the payment of tuition for them to public schools of all levels in which they may enroll, and the use of such payments to supplement, not substitute for regular State or local school appropriations.

6. We demand that the teachers of our Nation receive salaries commensurate with their position as leaders in the community.

7. We favor raising to cabinet level the Federal Security Administration.

8. We favor the establishment of entrance requirements to the military academies on the basis of free competitive examinations, and without congressional appointment.

VIII. Science

1. We urge the establishment of a national science foundation to promote, encourage, and coordinate research and education in all natural, social, and medical sciences; and we recommend that the results of such research be made freely available for public use.

IX. Congressional reform

1. We urge a complete overhauling and streamlining of congressional procedures.

2. We oppose the seniority system in congressional committees.

3. We favor the right to impose cloture in the Senate by simple majority vote.

4. We favor providing Members of Congress with more and better research and staff facilities, higher salaries, and retirement pay consistent with the pension fund for Federal employees.

5. We urge that congressional proceedings be broadcast from the floor.

6. We favor the regulation of the activities of all lobby groups and the publicizing of the sources of their funds.

7. We urge the registration by Members of Congress of their sources of income, and the registration of all dealings in securities and commodities by Members of Congress and members of their immediate families.

X. Discrimination and civil liberties

1. We oppose Jim Crow laws, anti-Nisei restrictions, and all other forms of racial discrimination by all individuals, by private businesses, by labor unions, government, and other associations. We forbid it in our own ranks and we shall fight it in law and in practice wherever it is found.

2. We strongly and actively oppose any laws, practices, customs, or usages whereby any person or group by virtue of discrimination due to race, religion, color, or sex attempts to prevent another from obtaining employment, being paid at a fair rate for the services performed, living in any area, obtaining a free and sound education, practicing any creed, or voting or enjoying any right of citizenship.

3. We urge laws to make such discrimination illegal and punishable, and to give members of minorities the right to sue for libel or slander against the whole majority group.

4. We strongly urge support of all movements for a permanent Federal fair employment practices law.

5. We urge that veterans organize to cooperate with other similarly minded groups and with governmental law enforcement authorities to protect civil liberties particularly in such regions where they are now threatened.

6. We favor effective Government action to preserve, protect, and implement the civil liberties granted in the Constitution and other laws of the States and the United States.

7. We urge abolition of the House un-American Activities Committee.

8. We support discharge of conscientious objectors from Federal custody but no faster than discharge of soldiers from the armed forces.

9. We urge a liberal immigration policy including immigration for all races, irrespective of the places of their origin, so that the United States may continue to serve as a refuge for the oppressed. We call upon Congress to enact legislation prohibiting immigration of all former members of Nazi and Facist parties.

10. We endorse the following corrective legislation:

(1) That all resident aliens not now eligible to become naturalized citizens of the United States be so privileged on the same basis as for all other immigrant groups:

2. That the Congress enact legislation providing indemnification for losses sustained by reason of the arbitrary evacuation of all persons of Japanese ancestry from the west coast in the spring of 1942:

(3) That deportation proceedings against persons of Japanese ancestry is carried out on the same basis as for other races; and

(4) That restrictive Federal, State, and municipal laws of a discriminatory nature be abolished and repealed wherever found.

XI. Tax policy

1. We consider fiscal policy to be critically important to full employment and full production. We therefore favor a tax program based upon ability to pay, to provide for the fullest development of our potential national resources, with the least possible restriction of production and employment, and inclusion in it of the

following provisions: (1) As the basic source of tax revenue, a steeply graduated personal income tax, and increased exemptions consistent with minimum levels of subsistence; (2) elimination of regressive excises and sales taxes; (3) financing of social-security benefits from the general revenues; (4) elimination of preferential tax treatment of capital gains and losses, with constructive realization of gains and losses upon gift or death; (5) elimination of tax-exempt securities; (6) removal of the tax advantage presently enjoyed by persons residing in community-property States; (7) elimination of double taxation of corporate income, coupled with an undistributed-profits tax to compel current distribution of corporate income to shareholders; (8) offsetting of individual and corporate income by a 6-year carry-forward of net operating losses; (9) restriction of depletion allowances of industries engaged in exploitation of natural resources to recovery of the capital investment in such properties; (10) heavy increases in estate and gift taxes and immediate closing of all present loopholes; (11) prohibition of refunds of excess-profits taxes where the decline in corporate income results from other than reconversion costs, e. g., labor disputes; (12) revision of State and local taxation consistent with above objectives and coordination of Federal, State, and local taxation.

XII. Suffrage

1. We urge that residents of the District of Columbia should, in common with all other citizens, enjoy the right of suffrage, upon a national and a municipal basis.

XIII. Territories and possessions

1. We favor the immediate admission of the Territory of Hawaii as the forty-ninth State; the consideration of Alaska for statehood; granting to the Virgin Islands increasing responsibilities of self-government; and giving to Puerto Rico the deserved right to vote on its political status.

2. We urge that there be no discrimination against the full citizenship rights of American Indians and that civil rights and citizenship be granted to the inhabitants of Guam and American Samoa. We further urge immediate civil rather than military government for the former Japanese mandated islands.

3. We believe that the continued subjection of Puerto Rico to colonial rule is contrary to our principles of national liberation and self-determination and to the principles of the United Nations, including the furtherance of world peace and justice between the peoples of all nations. In support of these principles, and to aid in establishing a basis for lasting friendship with Latin America, we urge that Puerto Rico be granted the right of self-determination in the creation of a democratic government, and that adequate economic assistance be extended to Puerto Rico to aid in the provision of its economic well-being.

CONSTITUTION OF THE AMERICAN VETERANS COMMITTEE

(Extension of remarks of Hon. Carl A. Hatch, of New Mexico, in the Senate of the United States, Friday, June 21, 1946)

Mr. HATCH. Mr. President, I ask unanimous consent to have printed in the Record the constitution of the American Veterans Committee, adopted at the constitutional convention of that organization in Des Moines, Iowa, June 14 to 16. The constitution of the AVC is typical of that group of World War II veterans in its high ideals and its emphasis upon democratic procedures. I believe that this group of young veterans has much to offer this country. The AVC has grown in recent months from a membership of 20,000 to more than 63,000 in 526 chapters in 44 States, and it is just embarking on a campaign for 1,000,000 members.

The Senator from Michigan and myself are cosponsors of legislation to grant a congressional charter to this organization. This newly adopted constitution serves to emphasize that this progressive group of World War II veterans should be given every opportunity to function nationally in their program for achieving a more democratic and prosperous America and a stable world.

I have secured from the Public Printer an estimate that the cost of printing the constitution of the American Veterans Committee will be $210, and that it will take up three and one-half pages of the Congressional Record. Notwithstanding that, I ask unanimous consent that it may be printed in the Appendix.

There being no objection, the constitution was ordered to be printed in the Record, as follows:

CONSTITUTION, AMERICAN VETERANS COMMITTEE

PREAMBLE

We, as veterans, of the Second World War associate ourselves regardless of national origin, creed, or color for the following purposes:

To preserve the Constitution of the United States; to insure the rights of free speech, free press, free worship, free assembly, and free elections; to provide thorough social and economic security to all; to maintain full production and full employment in our country under a system of private enterprise in which business, labor, agriculture, and government cooperate; to promote peace and good will among all nations and all people; to support active participation of this Nation in the United Nations and other world organizations whose purposes are to improve the cultural, commercial, and social relations of all peoples; to provide such aid to disabled veterans as will enable them to maintain the position in society to which they are entitled; to provide such financial, medical, vocational, and educational assistance to all veterans as is necessary for complete readjustment to civilian life; to resist and defeat all attempts to create strife between veterans and nonveterans; and to foster democracy. We dedicate ourselves to these aims, and for their attainment we establish this constitution.

Article I. Name

This organization shall be known as the American Veterans Committee, Inc., or such other name as may be adopted by the constitutional convention and approved by the proper authorities of the State of New York.

Article II. Organization

The several bodies constituting this organization shall be:

(a) The national organization which shall include:
(1) The national planning committee;
(2) The national administrative committee;
(3) The national officers;
(b) The State councils;
(c) The area councils;
(d) The chapters;
(e) Members at large.

Article III. Members

SECTION 1. The following persons shall be eligible for active membership regardless of national origin, creed, or color:

(a) Any person who serves or has served honorably on a full-time status in the armed forces of the United States at any time during the period from September 16, 1940, to the termination of the Second World War;

(b) Any citizen of the United States who serves or has served honorably on a full-time status in the armed forces of any of the other United Nations at any time during the period of such participation in the Second World War;

(c) Any person who serves or has served honorably on vessels of the merchant marine of the United States or honorably on active administrative duty in the United States Maritime Service for at least 60 days during the period from September 16, 1940, to the termination of the Second World War.

SEC. 2. Questions relating to interpretation of section 1 of this article shall be determined solely by the national planning committee.

SEC. 3. No member of this organization who shall have been accepted for membership under any bylaw adopted by this organization prior to the adoption of this constitution shall be deprived of his membership rights as a result of the adoption of this article.

SEC. 4. Active life memberships: Persons eligible for membership under section 1 of this article, who are recipients of the Congressional Medal of Honor, or the equivalent award of any nation of the United Nations, shall upon application be awarded active life membership in this organization by the act of any chapter or of the national planning committee or the national administrative committee without at any time being subject to any financial obligation in connection therewith.

SEC. 5. Honorary memberships: A majority of the national planning committee only may award honorary membership in this organization to any person who has distinguished himself or herself in the performance of services to the people of the United Nations.

SEC. 6. No person shall be admitted to active membership in this organization until he or she shall have subscribed in writing to the basic principles of this organization as set forth in the preamble to this constitution.

SEC. 7. A chapter member is one who is affiliated with a chapter of this organization. A member-at-large is one who has joined the organization but who has not become a member of any chapter or being a member of a chapter has terminating his membership with such chapter and has retained only his membership in the organization.

SEC. 8. No person eligible for membership of this article shall be denied the same unless previously ousted as hereinafter provided.

SEC. 9. A member may be suspended or ousted only if the member has deliberately engaged in activities which are contrary to the purposes of the organization or inimical to its welfare.

SEC. 10. No chapter shall oust any chapter member from membership unless such ouster is approved by two-thirds of the chapter members present at any regularly scheduled meeting following due notice of such contemplated ouster, and no member-at-large shall be ousted except by action of two-thirds of the national planning committee present at any regular or special meeting thereof following due notice of such contemplated ouster.

SEC. 11. No member shall be suspended or ousted from membership except after due notice and a fair hearing as shall be provided in the bylaws: *Provided, however*, That no such ouster of a chapter member shall become final until reviewed by the national planning committee.

Article IV. National convention

SECTION 1. The supreme power of this organization shall be vested in the membership represented at the national convention.

SEC. 2. The national convention shall be held at least once in each calendar year at such time and place as shall be determined at the previous convention, or, in the absence of such designation, at a time and place determined by the national planning committee.

SEC. 3. Delegates to the national convention shall be limited to four classes of persons:

(a) Chapter delegates.
(b) Chairman of State councils.
(c) Members of the national planning committee.
(d) The elective national officers of this organization.

SEC. 4. (a) Elected national officers, members of the national planning committee, and chairmen of State councils shall each be entitled to one vote at the national convention, and shall not be entitled to hold proxy votes.

(b) Each chapter designated in addition to such proxy votes as he may hold, shall be entitled to a number of votes to be computed by dividing the total number of votes to which such chapter is entitled by the number of such chapter's delegates at the national convention.

(c) Members at large, as defined in article III hereof, not living in the area of jurisdiction of any general chapter, shall be entitled to vote by proxy in such manner as the national planning committee may determine.

SEC. 5. The national convention shall be governed by such rules and regulations as the delegates thereto, each having one vote for such purpose, may adopt.

SEC. 6. The number of delegates from each chapter shall be based on a delegate membership ratio to be determined for each convention by the national planning committee; provided, however, that each chapter shall be entitled to at least 1 delegate, and that no chapter shall be entitled to more than 10.

SEC. 7. Chapter delegates to the national convention shall be elected by each chapter at a regular meeting thereof after due notice of the purpose of the meeting.

Article V. National Officers and members of the national planning committee

SECTION 1. (a) The national convention shall elect a national chairman, a national vice chairman, and 16 members of the national planning committee, at least 8 of whom shall be deemed qualified by the convention's nominating committee, by reason of personal consent, to undertake the responsibility of serving on the national administrative committee.

(b) The delegates to the national convention from each of the eight regions hereinafter defined assembled in caucus at said national convention, shall nominate and elect a member of the national planning committee from the region represented by the said delegates. Said member shall be known as the regional vice chairman.

(c) The continental United States shall be divided into the following regions: New England: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut. Middle Atlantic: New York, Pennsylvania, New Jersey, Maryland, Delaware, West Virginia, Washington, D. C. Southeast: Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Tennessee, Kentucky, Mississippi. Southwest: Louisiana, Arkansas, Texas, Oklahoma. East Central: Ohio, Michigan, Indiana, Illinois. West Central: Wisconsin, Minnesota, Iowa, Missouri, Kansas, Nebraska, North Dakota, South Dakota. Mountain: Montana, Wyoming, Colorado, Utah, New Mexico, Arizona, Idaho. Coast: California, Nevada, Washington, Oregon.

SEC. 2. (a) The officers enumerated in section 1 of this article and the national planning committee shall serve for one term; provided, however, that nothing herein contained shall prevent the reelection of any office or member of the national planning committee.

(b) The word "term" as used herein shall designate the period from the adjournment of a national convention to the adjournment of the next succeeding national convention.

SEC. 3. (a) In the event of the resignation, death, or disability of the national chairman, the national vice chairman shall succeed to the office of chairman, and he shall act as national chairman in the latter's absence.

(b) A vacancy in the office of national vice chairman or on the national planning committee may be filled by any member receiving a majority of not less than one-half of the votes of the attending members of the national planning committee at any regularly scheduled meeting thereof or of any special meeting called for the purpose of filling such vacancy; provided, however, that if such vacancy on the national planning committee shall be among one of the members elected in accordance with the provisions of section 1b, then such vacancy shall be filled by a member from the same region.

SEC. 4. A national treasurer, a national secretary, a national field secretary, and a national counsel shall be selected by the national planning committee.

SEC. 5. The national officers shall have such powers and duties as may be prescribed by the bylaws; provided, however, that the national chairman shall be the chairman of the national planning committee and of the national administrative committee.

SEC. 6. (a) The national chairman and the national vice chairman shall serve on a full-time basis and shall be entitled to an annual salary of $8,000 and $7,500, respectively.

(b) The national secretary and the national field secretary shall serve on a full-time basis and shall be compensated for their services at rates to be determined by the national planning committee or the national administrative committee as the bylaws may provide, and the national council may be compensated in like manner for any official services rendered.

SEC. 7. The national planning committee or the national administrative committee, or those to whom they may designate such authority, may from time to time appoint and employ such other officers, agents, or employees as may to them appear desirable, upon such terms as they may deem wise.

SEC. 8. There shall be a director of veterans affairs who shall be selected by the national planning committee and who shall, among other duties assigned to him, have full power to authorize qualifying members of the chapters of this organization to represent veterans and to handle veterans' claims before the Veterans' Administration. Such qualified members shall be authorized to render service to members in presentation of claims pursuant to laws and regulations without charge.

SEC. 9. All officers and members of the national planning committee shall have been members of this organization for a period of no less than 60 days prior to their election.

Article VI. National planning committee

SECTION 1. The board of directors of this organization shall be known as the national planning committee and shall consist of 25 members, of whom 24 shall be elected in accordance with the provisions of article V, section 1. The national chairman shall be a member of the national planning committee ex officio.

SEC. 2. The national planning committee shall have general power to manage and control the affairs, business, and property of this organization between national conventions.

SEC. 3. The national planning committee may adopt such rules and regulations for the conduct of its meetings and the management of the affairs of this organization as it may deem proper, and not inconsistent with law, the constitution, or bylaws of this organization.

SEC. 4. Regular meetings of the national planning committee shall be held quarterly. Special meetings of the national planning committee may be called at any time by the national chairman on his own initiative or at the request of any eight members of the national planning committee.

SEC. 5. After each national convention the national planning committee shall meet within 36 hours after adjournment of the convention for the purpose of transacting such business as may be necessary. Said meeting shall be held at the site of the convention.

SEC. 6. At least one-third of the members of the national planning committee shall constitute a quorum at any meeting of the national planning committee; but a less number may adjourn any meeting from time to time until the quorum shall be present.

Article VII. National administrative committee

SECTION 1. The members of the national planning committee shall elect five of its members willing and able to participate in frequent meetings at the national headquarters, who in addition to the national chairman and the national vice chairman shall constitute the national administrative committee.

SEC. 2. The national administrative committee shall be elected by a majority of not less than one-half of the national planning committee at its meeting next succeeding the national convention.

SEC. 3. Vacancies in the national administrative committee may be filled by a majority of not less than one-half of the national planning committee at any regular or special meeting thereof.

SEC. 4. All the powers of the national planning committee, so far as the same may be lawfully delegated, shall be vested in, and may be exercised by, the national administrative committee when the national planning committee is not in session: *Provided, however*, That any action taken by the national administrative committee on matters of policy shall be subject to ratification by the national planning committee at its next regular meeting.

SEC. 5. Regular meetings of the national administrative committee shall be held at least biweekly. Subject to the foregoing, and such regulations as may be made by resolution of the national planning committee, the national administrative committee may fix its own rules of procedure and shall meet on such days and at such place or places as may be fixed by such rules. But, in every case, the presence of at least a majority of the members of such committee shall be necessary to constitute a quorum.

Article VIII. Special committees

SECTION 1. The national chairman, the national planning committee, or the national administrative committee, may from time to time appoint any standing or special committees which shall have, and may exercise such powers as shall be authorized by resolution of the national planning committee or the national administrative committee.

The term of any such special committee shall be determined by the national administrative committee, whichever may authorize its existence: *Provided, however*, That the term of any committee shall not exceed the duration of the term in which it is appointed. Such committee shall designate a chairman and report through such chairman to the national administrative committee or national planning committee at such time as may be directed, and shall fix its own rules of procedure and shall meet when and as provided by such rules, but in every case, the presence of a majority of the committee shall be necessary to constitute a quorum.

Article IX. Organization of territorial units

SECTION 1. The territorial units of this organization shall consist of chapters, area councils, and State councils.

SEC. 2. State councils shall be chartered by the national planning committee or the national administrative committee and shall be composed of the chapters within their respective States, and shall have such powers as may be prescribed in the bylaws.

SEC. 3. Area councils shall be chartered by the national planning committee or by the national administrative committee and shall be composed of chapters within their respective areas of jurisdiction as from time to time defined by the national planning committee or the national administrative committee, and shall have such powers as may be prescribed in the bylaws.

SEC. 4. Chapters shall be chartered by the national planning committee or by the national administrative committee and shall be composed of such members as shall join such chapters.

SEC. 5. All charters heretofore granted are hereby affirmed.

SEC. 6. The minimum membership of any projected chapter shall consist of at least 10.

SEC. 7. No chapter shall be named after any living person.

SEC. 8. (a) Chapters in this organization shall accept for membership any member at large or any eligible applicant and shall make no distinction based on national origin, creed, or color.

(b) No member shall be a member of more than one chapter at any one time.

SEC. 9. Absolute discretion consistent with this constitution and the bylaws with respect to the granting of a charter to any Territorial unit shall vest in the national planning committee or the national administrative committee and the bylaws shall contain such provisions as may be necessary to insure democracy within such units and to provide for the fullest participation and representation of the membership therein.

SEC. 10. The national planning committee may, by a two-thirds vote of its members, revoke the charter of any Territorial unit for any of the following reasons:

(a) Deliberate attempts to obstruct or contravene the principles, purposes, and general policies of the organization as stated in the preamble.

(b) Fraudulent or illegal acts, calculated to destroy the credit or reputation of this organization.

(c) Protracted failure to hold regular meetings or to maintain a membership of at least 10 members.

SEC. 11. No charter shall be revoked except upon due notice to the Territorial unit involved and an opportunity for an adequate hearing and review.

SEC 12. In the event of revocation of a charter, the assets of the Territorial unit shall, after the payment of all debts, be appropriated by the national planning committee to be distributed among other Territorial units in such manner as the national planning committee may direct, consistent with the provisions of law.

Article X. Auxiliary organizations

(a) A Women's Auxiliary of this organization is hereby created, and the national planning committee shall proceed forthwith to establish such regulations for its organization and activities as it may deem advisable to permit it to assist in the carrying out of the purposes of this organization.

(b) The national planning committee by a vote of two-thirds of the members assembled at any regular or special meeting may authorize the creation of and establish regulations for such other auxiliary organizations as it may deem advisable for the carrying out of the purposes of this organization.

Article XI. Dues and finances

SECTION 1. The revenue of the national organization shall be derived from annual membership dues and from such other sources as may be approved by the national planning committee or by the national executive committee.

SEC. 2. National dues, and the dues of all subordinate units, for each member shall become payable annually on the first day of the month in which such dues were originally received.

SEC. 3. For a member at large the national dues shall be $5 per annum.

SEC. 4. In the event that a member at large shall become a chapter member during the fiscal year, the national organization shall contribute the sum of $2 to such chapter: Such sum shall be credited by the chapter to the chapter dues of such member.

SEC. 5. For a chapter member the national dues shall be $3 per annum.

SEC. 6. The status of any member for the purposes of this article shall be determined as of the date when such member's national or chapter dues as the case may be become payable.

SEC. 7. A chapter shall collect national dues from each of its chapter members and shall remit the same promptly to the national treasurer.

SEC. 8. For a chapter member chapter dues shall be at least $2 per annum.

SEC. 9. Any chapter may fix chapter dues in excess of the minimum provided in section 8 hereof by a majority vote of its members.

SEC. 10. In no event shall any member be compelled to pay any dues or assessments to the organization or any of its Territorial units in excess of a total of $7 in any fiscal year.

SEC. 11. Any member at large or chapter member whose national or chapter dues are in arrears for 3 months shall be notified by the chapter secretary or the national secretary, whichever is applicable, and if such arrears are not satisfied within 1 month thereafter, such member shall be dropped from the rolls as a member in arrears without prejudice to reinstatement, and if a chapter member, notice shall be given to the national office.

Article XII. Public policy

SECTION 1. All public statements made and political and social actions taken in the name of this organization shall be in consonance with the principles set forth in the preamble to this constitution.

SEC. 2. All such statements and actions when initiated by a Territorial unit shall be identified as coming from such territorial unit.

Article XIII. Endorsement of candidates

SECTION 1. Neither the national organization nor any Territorial unit shall endorse any candidate for public office; but this article shall not be deemed to prevent an unbiased presentation of the records of candidates nor to prevent the formation of or participation in any committee or organization endorsing or supporting a candidate for public office by members of this organization.

SEC. 2. Neither the funds of the organization nor of any of its units shall be used to support the candidacy of any person for public office.

Article XIV. Discrimination

Membership or office in or employment by this organization or any Territorial unit thereof shall in no way be conditioned upon the factors of national origin, creed, or color.

Article XV. Bylaws

SECTION 1. All presently existing bylaws consistent with this constitution or with any bylaws subsequently adopted shall continue in full force and effort unless amended or repealed by the national planning committee, the national convention, or by referendum.

SEC. 2. The national planning committee may adopt such bylaws consistent with the provisions of this constitution and with any bylaws adopted by the national convention or by referendum as it may deem necessary for the welfare of the organization.

SEC. 3. Bylaws adopted by the national planning committee may be amended or repealed by that body at any regular or special meeting thereof and any bylaw may be amended or repealed by the national convention or by referendum.

Article XVI. Initiative and referendum

SECTION 1. The national planning committee, the national administrative committee, or the membership by petition filed with the national secretary and signed by 2,000 members either personally or on their behalf by chapter chairmen signing on behalf of the total membership of their respective chapters and authorized so to do by a vote of a majority of each such chapter's members may initiate a referendum as to any of the affairs and business of the organization.

SEC. 2. Matters submitted to the membership by referendum shall be submitted by ballot to all chapters and members at large not living in the area of jurisdiction of any general chapter. A chapter ballot shall indicate its total membership and the total affirmative and negative vote of such chapter. A two-thirds vote of the membership voting in a referendum shall be binding upon this organization.

Article XVII. Amendment of the constitution

SECTION 1. This constitution may be amended by the national convention by a majority of the votes cast at the session of the national convention voting thereon, provided that the number of votes cast shall equal at least a majority of the total vote represented at such convention; or by referendum as provided in article XVI.

SEC. 2. No amendment shall be submitted to the national convention for its approval unless it shall have been previously approved by the national planning committee or shall be in the form of a petition filed with the national secretary and signed by 2,000 members either personally or on their behalf by chapter chairmen signing on behalf of the total membership of their respective chapters and authorized to do so by a vote of a majority of such chapter's members. Such petition shall be filed not less than 60 days prior to the date of the national convention.

SEC. 3. In the event that an amendment is proposed in accordance with the provisions of section 2 of this article, it shall be published in the national organ of this organization not less than 30 days prior to the date of the national convention.

Article XVIII. Reincorporation.

The national planning committee by vote of two-thirds of its members is empowered to reincorporate this organization as a national corporation or as a corporation existing under the laws of any State and to dissolve the present corporation and upon dissolution to transfer the assets and liabilities of the present corporation to the new corporation, provided that all of the members of the present corporation shall become members of the new corporation and that all of the aforesaid shall be done only in accordance with law and the provisions of this constitution.

Article XIX. Nonprofit

No part of the earnings, income, or funds of this organization shall enure to the benefit of any member or individual except that this organization may pay consideration for work, labor, or material furnished to it.

Senator DONNELL. The committee will be in recess until 9:30 a. m. tomorrow.

(Whereupon, at 1:15 p. m., a recess was taken until 9:30 a. m., Thursday, July 3, 1947.)

NATIONAL HEALTH PROGRAM

THURSDAY, JULY 3, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator Forrest C. Donnell, presiding.

Present: Senators Donnell (presiding), Ball, Murray, and Pepper.

Senator Donnell. The committee will be in session.

Is Dr. Butler here?

Dr. Butler. I was listed as second and would prefer waiting.

Senator Donnell. I have you listed as first, but we will wait. Is Mr. Rymer here?

Mr. Rymer. Yes, sir.

Senator Donnell. Will you please state your name and your address and for what organization you appear?

STATEMENT OF ERNEST N. RYMER, REPRESENTING INTERNATIONAL WORKERS ORDER

Mr. Rymer. My name is Ernest N. Rymer and my home address is 302 Eastman Parkway, Brooklyn, N. Y. I represent the International Workers Order, which, in addition to supplying insurance benefits also operates a voluntary prepaid plan of limited medical services in several large cities. In New York City our medical department serves almost 20,000 persons. Our membership is composed of working people who are of many different races and national origins. They work in many types of industries and live in the major national group communities of the Nation. From that standpoint, we represent a fairly typical cross section of America's working population. We also have among our members many persons from professional and small business groups.

Both as an insurance organization and a membership society with family units which face economic difficulties in obtaining adequate medical care, we have been and are deeply interested in a national health program. The International Workers Order, since its organization in 1930, has worked for an adequate social-security and national health program.

At the last regular convention of the International Workers Order, held in New York from June 16 to 18, 1947, a resolution was unanimously adopted which opposed S. 545, the National Health Act of

1947, and endorsed S. 1320, the National Health Insurance and Public Health Act of 1947. This resolution was approved by 274 elected delegates representing over 1,800 lodges.

All persons concerned with the progress and well-being of the country recognize that the problem of preserving, maintaining, and improving the health of the population has become one of the most urgent social tasks of our times. Large sections of our people are suffering from serious and dangerous shortcoming in health opportunities because of the present outmoded and unequal method of distributing medical care. There are abundant statistics to bear this out. A. J. Altmeyer, Chairman of the Social Security Board, bluntly summed it up, and I quote:

> There are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

We would like to add to this, that because of discriminations the Negro citizens of our country suffer worst of all in matters of health and medical care. Why is this true in a land which boasts of such abundance? The fundamental reason has been stated and restated now for a number of years. There is a financial barrier which stands between the majority of our people and the medical services which America can provide. Various public-opinion polls reveal that from 30 to 40 percent of the American people put off going to a doctor because of cost.

The Rockefeller Foundation, in its annual review of 1947, puts the case this way, and we quote:

> One of the troublesome problems of our generation is how we are to make available to the entire population the preventive, diagnostic, and curative services of modern medicine.

Any proposal that purportedly sets out to solve this problem must be measured by this prerequisite: That it make available to the entire population the all-around medical services it needs for maintaining and enjoying health.

Testing S. 545 in relation to the health needs of the country, we find that its provisions fail utterly in every respect to solve the underlying problems. We find that we cannot even support this bill as a step in the right direction. On the contrary, from our point of view, this bill would push the Nation back on the road to constructive social legislation. In our written testimony we have presented more detailed objection to S. 545.

In summary, our objections are these:

It cannot and will not solve the problem of providing all-around diagnostic, curative, and preventive medicine to all the population regardless of income status. It evades completely the only assured method of providing medical care for the vast majority of the people who are unable to pay as individuals—and that method is a national system of health-insurance payments operated as part of the social-security system along with old age and unemployment insurance.

It would establish an obnoxious principle that those who cannot pay for present medical costs are charity cases. It would place control of America's health program in the hands of the medical profession without allowing an effective voice for the consumer, labor, the Negro people, and other groups representing the public. In its essence, the bill would sidetrack and hold back the passage of genuine progressive health legislation.

Based upon our experience as a fraternal insurance organization and judging from the limitations and shortcomings of our own voluntary medical plan, we are convinced that our national health problem can only be solved through a system of prepaid Federal health insurance such as is embodied in S. 1320, the National Health Insurance and Public Health Act. This plan would be part of our social-security system and would be paid along the lines of unemployment and old-age insurance. It would provide all-around medical and hospital care, including dental care and eye care. It would pay for X-rays, laboratory, and other costs.

Except for minor differences, we agree with its method of administration. National standards would be firmly established and assured by the Federal Government while actual administration of the act would be handled by State and local bodies. Its nondiscrimination clause has a better chance to be honored, since the bill would be under Federal supervision. Prepaid medical insurance to be federally provided does not strike a member of a fraternal organization as a radical departure. Insurance methods involving the principle of sharing the risk, distributing the costs, cooperative pooling of funds for common needs—these practices are an old story in America. We have been doing it for years to obtain life insurance and other kinds of insurance.

The provisions of S. 1320 would simply put into operation the principles which benefit societies have practiced for years within their own organizations. The important difference, however, is that the matter of health is so great in scope and of such national concern that only one agency can successfully organize, operate, and direct a national health program—that is the Federal Government through the Federal Security Agency.

It is high time that the Government assume responsibility for this problem, as it has for unemployment and old age, education, and other matters of public welfare. We are convinced that the American people are ready and eagerly waiting for such a health program. For the progress and welfare of the Nation, we urge this committee to reject S. 545 and vote for S. 1320.

Senator DONNELL. Any questions, Senator Murray?

Senator MURRAY. No.

Senator DONNELL. I would like to ask Mr. Rymer some questions. Mr. Rymer, the International Workers Order has already become quite active by advertising and other methods the advocacy of S. 1320?

Mr. RYMER. The inadequacy?

Senator DONNELL. No, sir. I said became active in advertising in advocacy of S. 1320; is that right?

Mr. RYMER. That is right, sir.

Senator DONNELL. I have before me an advertisement—a photostatic copy of an advertisement appearing in the Worker of Sunday, May 25, 1947, purporting to be issued by the International Workers Order, 80 Fifth Avenue, New York 11. Is that the organization for which you speak here this morning?

Mr. RYMER. Yes, sir.

Senator DONNELL. I notice the date of that advertisement is May 25 of this year, which is just 5 days after the filing of this bill in Congress; that is, S. 1320. Now, how does it happen your organization was able to make so rapid a summary of this bill and prepare an advertisement here which covers at least three columns and maybe more?

Mr. RYMER. Well, sir, we have been supporting the general progression of bills like S. 1320 for the last few years already, sir, and we have kept pretty closely in touch with the committee and sponsors—Mr. Murray and Mr. Wagner and Mr. Dingell for a number of years already, and we probably ask them questions even before they proposed this bill and found out the very next day what they were considering to propose.

Senator DONNELL. Did anyone connected with the International Workers Order cooperate in the preparation of S. 1320?

Mr. RYMER. Not that I know of, sir, except, if I may put it this way, in hearings where they gave their opinions on the bill in previous years. I only hope the suggestions we might have made were taken into account and seem to have been in changes made this year.

Senator DONNELL. This issue of the Worker of May 25 sets forth among other things a summary of the main changes from the 1945–46 bill that consists of five different paragraphs. I should judge there are several hundred words in those five paragraphs. Who made that summary of the main changes between S. 1606 and S. 1320?

Mr. RYMER. We have a research staff of a number of people. I can give you their names.

Senator DONNELL. Who did this, if you know?

Mr. RYMER. I don't know exactly; I could find out.

Senator DONNELL. Did you do this?

Senator MURRAY. I might mention we prepared a summary of that and sent it out to all the witnesses who appeared in support of the measure in past years. We also supplied the American Medical Association witnesses, too.

Senator DONNELL. Do you know whether or not that is the way you got the information on which this advertisement was framed 5 days after the introduction of this bill in the Senate of the United States?

Mr. RYMER. I don't know, sir, but I can find out for you.

Senator DONNELL. You do not know. I observe down at the bottom of this advertisement and as a part of it is a little thing to be signed by an individual saying: "I am interested in the National Health and Public Health Acts of 1947. Send me more information about it." Does your organization have literature on the subject of S. 1320?

Mr. RYMER. We have summaries of the bill and we secure copies of the bill or send the names and addresses in here so they can be sent copies of the bill.

Senator DONNELL. To what people here?

Mr. RYMER. To the committee.

Senator DONNELL. Senate Committee on Labor and Public Welfare?

Mr. RYMER. Yes, sir.

Senator DONNELL. Did you at the time of this advertisement, May 25, already have information at hand in booklet or other form you could mail back to people who responded to the suggestion in this advertisement?

Mr. RYMER. Not that I know of.

Senator DONNELL. Not that you know of. I notice that this advertisement among other things refers to S. 545 in this language:

> One thing is certain—we, the American people, can't afford to permit the Republicans and reactionary Democrats to force upon us the Taft "health" bill, which is a shame and a mockery in terms of meeting the health needs of the Nation. The Taft bill is nothing less than a charity measure. It must not pass.

Let me ask you: What is the publication, the Worker, and by whom is it put out?

Mr. RYMER. As far as I know, it is a paper that is published where it is addressed there.

Senator DONNELL. It is not on here. This is a photostatic copy. I am asking you who puts it out; do you know?

Mr. RYMER. I don't know the exact name of the publishing company.

Senator DONNELL. Do you know whether it is the Communist Party?

Mr. RYMER. I don't know, sir.

Senator DONNELL. You don't know that?

Mr. RYMER. I don't know.

Senator DONNELL. You don't know that the Daily Worker, of which this is the Sunday edition is a publication put out by the Communist Party in the United States?

Mr. RYMER. No: I don't know, sir.

Senator DONNELL. You don't know that?

Mr. RYMER. No, sir.

Senator DONNELL. Did you ever hear any such thing?

Mr. RYMER. I heard it was associated but I don't know it actually publishes it.

Senator DONNELL. You have heard it was associated in some way with the Communist Party? You knew as a matter of fact, didn't you, that it reflects the opinions of the Communist Party, didn't you?

Mr. RYMER. No doubt.

Senator DONNELL. No doubt you know that, don't you?

Mr. RYMER. That is right.

Senator DONNELL. That is generally known throughout the country?

Mr. RYMER. I suppose so.

Senator DONNELL. You know so, don't you?

Mr. RYMER. I don't know what the opinion of the country is.

Senator DONNELL. Of course, you haven't taken a poll of 140,000,000 people, but you know as a matter of general public knowledge that the Worker is the publication which sets forth the sentiments and views of the Communist Party, don't you?

Mr. RYMER. Yes, sir.

Senator DONNELL. All right. Now, Mr. Rymer, what is your business yourself?

Mr. RYMER. I work for the International Workers Order.

Senator DONNELL. How long have you worked for them?

Mr. RYMER. Oh, 8 to 12 years.

Senator DONNELL. Eight to twelve years?

Mr. RYMER. Yes.

Senator DONNELL. Where were you born?

Mr. RYMER. In Russia.

Senator Donnell. What is the date of your birth?

Mr. Rymer. December 27, 1908.

Senator Donnell. When did you come to this country?

Mr. Rymer. About 1920, '21.

Senator Donnell. What was it?

Mr. Rymer. 1921, I believe.

Senator Donnell. Don't you know?

Mr. Rymer. I have it recorded.

Senator Donnell. Well, don't you know what year you came to this country?

Mr. Rymer. It was '21.

Senator Donnell. 1921. Are you a naturalized citizen of this country?

Mr. Rymer. That is right.

Senator Donnell. When did you take out your citizenship papers?

Mr. Rymer. I became a citizen under the citizenship papers of my father. I was under age at that time.

Senator Donnell. You became a citizen because your father became a citizen. You located in New York, did you, in 1921; is that right?

Mr. Rymer. That is right.

Senator Donnell. You lived either in New York or Brooklyn ever since?

Mr. Rymer. Yes.

Senator Donnell. Between 1921 and the time you became connected with the International Workers Order, what did you do?

Mr. Rymer. I have gone to school.

Senator Donnell. What school did you attend?

Mr. Rymer. Stuyvesant School, public schools.

Senator Donnell. Any other schools?

Mr. Rymer. I attended college for 1 year.

Senator Donnell. Which college?

Mr. Rymer. City College of New York.

Senator Donnell. What else did you do after that?

Mr. Rymer. I have worked as an electrician, as a caster, a textile block worker, laundry worker.

Senator Donnell. Were you connected with any labor organization?

Mr. Rymer. I worked for a community center in New York.

Senator Donnell. I mean any labor unions?

Mr. Rymer. No, sir.

Senator Donnell. What year did you first start to work with the International Workers Order?

Mr. Rymer. 1937.

Senator Donnell. Now, you referred in your testimony to the International Workers Order as a fraternal organization, did you not?

Mr. Rymer. That is right.

Senator Donnell. And stated it was organized in 1930?

Mr. Rymer. Yes, sir.

Senator Donnell. Do you know anything about the actual extent of its fraternal insurance business?

Mr. Rymer. In a general sense.

Senator Donnell. Do you know what the volume of that is in annual receipts?

Mr. Rymer. I have this information.

Senator DONNELL. Could you tell us what the annual receipts are, approximately?

Mr. RYMER. I don't know what the receipts are over the year.

Senator DONNELL. What information do you have there as to the actual operation of the fraternal insurance?

Mr. RYMER. Well, I can tell you that, for instance, we have in the 16 years of existence paid out about $10,000,000 in cash benefits. We have cash reserves of about $4,000,000. We are valued, that is, our solvency is valued, at 147.7 percent. That is about the general remarks. You can get more specific information——

Senator DONNELL. From the insurance department in New York?

Mr. RYMER. Yes, sir.

Senator DONNELL. Do you know it to be a fact that the Daily Worker is published by the Comprodaily Publishing Co., Inc., at 50 East Thirteenth Street, New York?

Mr. RYMER. I think that is right.

Senator DONNELL. You know that the owners of that paper are Earl Browder, M. Greenbaum, and A. Markoff; you know that?

Mr. RYMER. From what I have read.

Senator DONNELL. It is your general understanding; is that correct?

Mr. RYMER. Yes.

Senator DONNELL. You know that Earl Browder is the head of the Communist organization?

Mr. RYMER. Yes.

Senator DONNELL. That is the same man?

Mr. RYMER. I suppose it is, sir.

Senator DONNELL. You know it is, don't you, the same man who is connected with the Daily Worker who is with the Communist organization?

Mr. RYMER. Yes, sir.

Senator DONNELL. Just speak a little louder.

Mr. RYMER. I believe so.

Senator DONNELL. Yes; all right. Mr. Rymer, this organization of yours was formed, as you say, in 1930. Who was the first head of your order; do you remember his name?

Mr. RYMER. No; I don't, sir; but it might have been Mr. Shiller or Mr. Saltzman.

Senator DONNELL. Mr. Shiller or Mr. Saltzman. What is your connection with this organization?

Mr. RYMER. I am directing youth activities in the Jewish people's fraternal order part.

Senator DONNELL. Do you have a Max Bedacht?

Mr. RYMER. Yes.

Senator DONNELL. He was national general secretary of the International Workers Order?

Mr. RYMER. Yes.

Senator DONNELL. When was he general secretary?

Mr. RYMER. He has been for a number of years, up to this year.

Senator DONNELL. He is now out?

Mr. RYMER. Yes.

Senator DONNELL. He was the general secretary of the International Workers Order for a number of years?

Mr. RYMER. Yes.

Senator DONNELL. Do you know, approximately, how many?

Mr. **Rymer**. No.

Senator **Donnell**. Say, 10 years; would that be your best estimate?

Mr. **Rymer**. Yes, sir.

Senator **Donnell**. You know that Mr. Bedacht preceded Earl Browder as executive secretary of the Communist Party, do you not?

Mr. **Rymer**. I didn't know that, sir.

Senator **Donnell**. Well, you know that Mr. Bedacht was executive secretary of the Communist Party at one time, do you not?

Mr. **Rymer**. He might have been. I don't know.

Senator **Donnell**. You have heard it?

Mr. **Rymer**. No; I haven't, sir.

Senator **Donnell**. You never heard that. You knew that Mr. Bedacht was the Communist Party candidate for Senator from New York in 1934; did you not?

Mr. **Rymer**. I don't recall, sir.

Senator **Donnell**. You don't recall?

Mr. **Rymer**. No, sir.

Senator **Donnell**. You never heard that?

Mr. **Rymer**. Not that I know of, sir.

Senator **Donnell**. You know William Weiner?

Mr. **Rymer**. I do know him, sir.

Senator **Donnell**. Was he former president of the International Workers Order?

Mr. **Rymer**. Yes.

Senator **Donnell**. Was he connected with a passport fraud in 1940?

Mr. **Rymer**. I don't know the actual terms.

Senator **Donnell**. You heard about that?

Mr. **Rymer**. Yes, sir.

Senator **Donnell**. You heard of that criminal case involving Mr. Weiner on a passport matter?

Mr. **Rymer**. Yes, sir.

Senator **Donnell**. You don't know the details?

Mr. **Rymer**. No.

Senator **Donnell**. You know that William Weiner, while president of the International Workers Order, served as national treasurer of the Communist Party?

Mr. **Rymer**. I didn't know that.

Senator **Donnell**. You have heard that; haven't you?

Mr. **Rymer**. I haven't, sir.

Senator **Donnell**. You know that Mr. Weiner was at one time national treasurer of the Communist Party; do you not?

Mr. **Rymer**. I don't know that, sir.

Senator **Donnell**. You never heard of that, sir?

Mr. **Rymer**. No; I haven't, sir.

Senator **Donnell**. Does your organization get out a so-called convention bulletin which they have at their national conventions?

Mr. **Rymer**. Usually; yes, sir.

Senator **Donnell**. I have before me a convention bulletin of Tuesday, July 4, 1944, on page 1 of which is an article entitled "William Weiner Resigns," and just a portion of it reads as follows:

> The resignation of William Weiner, president of the International Workers Order, submitted previously to the resident executive board of the society, was read before and accepted by the delegates to the sixth national convention of the I. W. O. at Manhattan Center in the morning session of Monday, July 3.

Do you remember that incident?

Mr. RYMER. What year was that?

Senator DONNELL. 1944—3 years ago tomorrow.

Mr. RYMER. What month?

Senator DONNELL. July 4—the 4th day of July.

Mr. RYMER. Yes; I recall that.

Senator DONNELL. I read just a portion of that. Let me continue:

> Brother Weiner was a founding member of the I. W. O. For 12 years he has been its president.

Did you know that?

Mr. RYMER. Yes.

Senator DONNELL. Very well. You say that you did or did not know that Mr. Weiner was the national treasurer of the Communist Party at one time?

Mr. RYMER. I didn't know that.

Senator DONNELL. Mr. Rockwell Kent—is he the president of the present organization?

Mr. RYMER. Yes.

Senator DONNELL. You do know that Kent has openly declared his Communist faith?

Mr. RYMER. I don't know that, sir.

Senator DONNELL. Have you ever heard that?

Mr. RYMER. No, sir.

Senator DONNELL. Do you sit on the inner council meetings of the International Workers Order?

Mr. RYMER. Yes.

Senator DONNELL. And you never heard of the fact that Rockwell Kent has openly declared his Communist faith?

Mr. RYMER. No, sir.

Senator DONNELL. Never heard that?

Mr. RYMER. No, sir.

Senator DONNELL. You know nothing about it one way or the other?

Mr. RYMER. I have hardly heard Mr. Rockwell Kent speaking.

Senator DONNELL. You have heard of Herbert Benjamin?

Mr. RYMER. Yes, sir.

Senator DONNELL. Is he the present head of the Communist Party association in my own State of Missouri?

Mr. RYMER. I don't know.

Senator DONNELL. You do know he is former general secretary of the International Workers Order; do you not?

Mr. RYMER. That is correct. Executive secretary, I believe.

Senator DONNELL. Executive secretary. Do you know Louise Thompson?

Mr. RYMER. Yes, sir.

Senator DONNELL. Is she connected with both the International Workers Order and the Communist Party?

Mr. RYMER. I know she is connected with the International Workers Order.

Senator DONNELL. Is she connected with the Communist Party?

Mr. RYMER. I don't know.

Senator DONNELL. Have you heard of Reuben Saltzman?

Mr. RYMER. That is right.

Senator DONNELL. Do you know whether he is connected with the International Workers Order at this time?

Mr. Rymer. Yes.

Senator Donnell. Is he also with the Communist Party?

Mr. Rymer. I don't know, sir.

Senator Donnell. Do you know Joseph R. Brodsky?

Mr. Rymer. Yes, sir. He is general counsel.

Senator Donnell. General counsel for the International Workers Order?

Mr. Rymer. Yes, sir.

Senator Donnell. Is he also with the Communist Party?

Mr. Rymer. I don't know, sir.

Senator Donnell. Mr. Harry Shiller? That is the Shiller you referred to? Is he connected with the International Workers Order?

Mr. Rymer. That is right.

Senator Donnell. Is he connected with the Communist Party?

Mr. Rymer. I don't know, sir.

Senator Donnell. Very well. Mr. Rymer, do you know as a matter of fact that the International Workers Order has consistently supported the candidates of the Communist Party both locally and nationally; you know that, don't you?

Mr. Rymer. I don't know.

Senator Donnell. You don't know that to be a fact?

Mr. Rymer. No, sir.

Senator Donnell. I have, for instance, here in my possession certain campaign literature as of August 1932. It is entitled "Vote! For Whom and for What?" It is issued by the campaign committee of the International Workers Order. Did you ever hear of that publication?

Mr. Rymer. No; I haven't, sir.

Senator Donnell. You haven't heard of it?

Mr. Rymer. Might I see it?

Senator Donnell. You have heard of William Z. Foster?

Mr. Rymer. Yes, sir.

Senator Donnell. Is he connected with the Communist Party?

Mr. Rymer. Yes.

Senator Donnell. I read the concluding portion of this printed campaign document which I will ask to have a copy of the entire document incorporated in the record.

(The copy of the campaign document follows:)

Vote! For Whom and for What?

(Issued by the Campaign Committee of the International Workers Order, August 1932)

We are facing an election. A Presidential and congressional campaign has brought to the front all political parties with platforms and candidates bidding for the support of the voters.

The members and the friends of the International Workers Order will participate in this campaign. They are entitled to guidance and advice in this activity.

The International Workers Order is not a political party. It is a mutual aid society; but it is primarily a labor organization. Like other labor organizations it performs a definite function for the workers. The function of a labor union is to guard the immediate economic interests of the workers and to organize them for their defense. The function of a political party of the workers is to organize and lead the working class for and in its political struggle. The purpose of the International Workers Order is to help the workers financially in certain emergencies.

The workers find themselves in a most difficult social position. They are members of a class that has no other income but wages. Their ability to collect this income depends upon jobs. These jobs are owned and controlled by the capitalists. The capitalists therefore own and control the workers' only chance to live. Since the workers can only live when they have jobs, and since they can get jobs only by permission of some capitalist, they can only live by permission of the capitalists.

There are many occasions and many reasons for the capitalists to withhold from the workers permission to work. At present they are withholding this permission from about 15,000,000 workers because an economic depression makes the running of the factories unprofitable. But though the factories stopped running the stomachs of these 15,000,000 unemployed workers desire continuous operation. These 15,000,000 workers still need food, clothing, and shelter. But they are unable to get them.

The capitalists withhold the jobs from them and without jobs the workers are without the means to provide themselves and their families with food, clothing, and shelter.

Another occasion for the capitalists to withhold jobs from the workers is when the workers are sick. Most jobs breed sickness for the workers in the form of occupational diseases. Yet when sickness overtakes the worker he is deprived of his job; he is deprived of his income; he is consequently deprived of the means to live.

When the worker gets old a like fate overtakes him. Because his ageing muscles can no longer adapt themselves to the merciless speed of modern machine efficiency the old worker cannot find employment. Though depending on wages for a living he is deprived of this chance to earn wages. Consequently he is deprived of his chance to live.

To take care of the workers thus deprived of their chance to live is clearly a social duty. Although the job of the individual worker is depended upon the private permission and interest of the individual capitalist—yet the worker's labor is a social service. The life of the worker therefore must be a social concern. At this moment, however, organized society does not concern itself with this problem.

In this emergency the workers organize themselves for the purpose of mutual aid. The International Workers Order is such a workers' mutual aid society. Its clear and undisguised purpose is to organize the workers so that they may try to solve, by mutual efforts, a problem which they cannot solve by individual efforts. This is, and this alone can be, the basic purpose of any workers mutual aid society.

There are many mutual aid societies, however, that try to defeat this purpose. Numerous mutual aid organizations put religion, nationalism, patriotism, or mysticism into the foreground. Effective mutual aid requires workers unity. The principle of religion with its numerous systems, the principle of patriotism basing itself on numerous nationalities, and the principle of mysticism basing itself on many varieties and stages of romanticism, are all factors which divide the workers. These factors are consciously put into the foreground by the enemies of the workers. The carrying through of universal workers unity for effective mutual aid would develop among the workers an understanding of their mutual interests. It would develop united action between them for the solution of their mutual problems. For instance: If the workers of the United States were not divided into numerous religious mutual-aid organizations, serving different gods, or serving the same God in different ways; if they were not divided into numerous nationalist mutual-aid societies serving different patriotisms; if they were not divided into numerous secret societies, serving different systems of meaningless mysticism; if, instead, they were organized into one workers mutual-aid society serving one common workers purpose there would be one united mutual aid group of millions of workers whose united demand for social insurance even the most arrogant government could not and would not disregard.

The enemies of the working class dread the possibility of such unity. They fear united action on the part of the workers. That is why on every occasion, and surely where workers unity is most important, they put into the foreground principles and issues that divide the workers. That is why the many existing mutual aid societies are not based upon the principle of unity of the workers for purposes of effective mutual aid but are based rather on division of the workers along the lines of religion, nationalism, or mysticism.

The International Workers Order differs in this respect from all other mutual-aid societies. It bases its organization on the working class as a whole. It considers detrimental to the workers all the principles and issues that divide them. It considers of imperative necessity the acceptance and practice of the principle of workers solidarity, regardless of race, nationality, creed, or color. That is why in the ranks of the International Workers Order there are organized workers of many nationalities. At their branch meetings the members of the order talk the tongue of their respective nationality; but throughout the order, in all branches and in all tongues, they speak the language of the working class, and they talk about the problems of the working class.

The International Workers Order refuses to appeal to the workers on questions on which they differ—on religious, national, or mystic questions. It appeals to the workers on the one thing they have in common; their mutual economic needs and interests.

Organized along these lines the International Workers Order practices the principles of mutual aid by insuring its members against various emergencies. Benefits are paid to members in case of sickness or death; benefits are also paid in the form of free medical aid to the members and their families, as well as in the form of contributions toward funeral expenses, in the form of children insurance and in various other forms. All these benefits are secured at the lowest possible membership fees.

The International Workers Order recognizes, however, that all this aid and all this help to its members is, at best, only an emergency measure. If we had any desire to forget this, the present conditions would remind us.

The workers have always seen their economic insecurity. But they fell victims to a propaganda designed to make them underestimate their own insecurity. The capitalists told the workers that they could protect themselves against need in times when they cannot earn, by saving in times when they do earn. The slogan was "In times of prosperity save money; put something away for a rainy day." They did put something away for a rainy day. But when the rainy day came around they found that somebody had run off with the umbrella. The banks that held their savings were closed.

The workers in the mutual-aid organizations have an experience different in kind, similar in effect. They banded themselves together for purposes of mutual aid in times of need. But now when this need has risen highest the workers find themselves unable to maintain their membership in the mutual-aid organizations. They cannot pay their dues. They lose a chance to be helped exactly at the moment when such help is more imperatively needed and is harder to get than at any other time.

Constantly reminded of the utter inadequacy of voluntary mutual-aid efforts among the workers the International Workers Order considers it its duty to organize the workers so that they may demand and obtain help from the state and its government. By organizing voluntarily for mutual aid we have not even for a moment waived our right to social aid. The workers are entitled to this social aid.

The workers are the most useful and most necessary part of society; with their labor they maintain society. At the same time their labor is the only means by which they can maintain themselves. When society refuses the workers a chance to use their labor and thereby refuses them a chance to maintain themselves, the duty of maintaining the workers clearly falls on the shoulders of society.

Society must perform this duty by means of an extensive and adequate system of social insurance.

Social insurance is a system of insurance and pensions for the workers which secures the workers lives and existence under all conditions.

Unemployment insurance shall secure the workers income when the refusal of capitalist industry to employ them takes their incomes away.

Disability insurance shall protect the workers in case of sickness, accident, or other causes of disability which deprives them of their chance to earn their living in the form of wages.

Maternity insurance for working women shall secure adequate help for working mothers at a time when they are prevented from earning a living or forced to earn it at a time when their labor is a threat to the life and health of mother and child.

Old-age pension shall secure an adequate income for workers whose gray hair and weakened muscles cause the capitalists to refuse them a chance to earn a living through a job.

Such a system of social insurance is at present a question of the very existence for the working class. The International Workers Order recognizes this. It recognizes that its own insurance features, though maintained at the lowest possible cost for its members, are inadequate. The International Workers Order would not perform its duty toward its members if it would not point out to them this inadequacy. The International Workers Order would consider it a neglect of duty toward its members if it would not tell them: Our effort of mutual help can not entirely solve our problem. The only effective solution is an extensive system of social insurance. Therefore we must fight for social insurance. We must use our mutual aid organization as a means of immediate emergency help; and at the same time we must use it as a base to unify the workers for the struggle for social insurance.

It is this struggle for social insurance that fixes the interest of the International Workers Order at this moment on the current election campaign.

The struggle for social insurance is a political struggle. The International Workers Order, not being a political party, cannot and does not enter the election campaign with an independent program and with independent candidates. The political interests of its members are identical with the political interests of great masses of workers not yet organized in its ranks. These political interests must find expression in the program, and the struggle for these political interests must find leadership in the activities of some existing party. We endeavor to find this political party by searching the programs and the activities of the various parties in regards to social insurance. The party that defends the interests which are the interests of our members, the party that fights for the things we fight for, must receive our support.

Our participation in the election campaign is not foreign to the purposes of our order. We demand social insurance. We propagandize for social insurance. We fight for social insurance. In the present election campaign we shall therefore also vote for social insurance.

The present economic crisis has put social insurance into the foreground of all the needs of the workers. We must therefore judge the political parties by the importance they attach to this problem and by the proposals they formulate to solve it.

Here we find that when the involuntary murmurings of millions of empty stomachs of the workers for bread have risen to the volume of a tremendous cry that drowns every other sound, the only echo that this cry could produce in the conventions and platforms of the two major political parties is the feeble whispering for 3-percent beer—maybe.

The Republican Party is the party in power. Is there one act to its credit that was designed to lessen the plight of the unemployed masses? Has the Republican Party made even a single gesture toward any measure of social insurance? Has it done anything that would justify us to recommend to the members of the International Workers Order the support of the platform and the candidates of the Republican Party?

The answer to all of these questions is an emphatic "No."

For the masses of workers the paramount question in the present election campaign is, What will the Government do for the unemployed? President Hoover answered this question for the Republican Party in a radio speech last fall when he declared that it is not the business of the Federal Government to take care of the unemployed. Then he turned around and invented the Reconstruction Finance Corporation to help the bankers. At a time when millions of workers need help, at a time when the Government party categorically declares that it does not consider it its duty to help them, what earthly reason is there for the workers to give that party and its candidates their confidence and their votes?

The basic principle of the Republican Party is that business alone is entitled to protection; the lives of the masses are not. Billions are raised to help the bankers. Not a cent is raised to help the workers.

We conclude from all this that a party that does not consider it its duty to help the workers cannot expect the workers to consider it their duty to help that party.

The platform of the Republican Party strongly endorses the stand of President Hoover and declares that relief is the concern of the State and local governments and of private charity.

As to charity, the International Workers Order is of the opinion that it is an insult to the workers. The workers accept it today as the only source of help; but they accept it with resentment. Society lives by the workers' labor. For this service society makes the workers eat out of the hands of charity. The very thought is insulting. This insult is aggravated when charity refuses to act on the basis of the needs of the applicant but first ascertains his "worthiness" by finding what god he prays to, what political principles he believes in, and in what country he was born. It seems that the world we live in can do nothing to the workers without slapping them in the face. Even when this society is charitable toward the worker it acts with a poisonous sting hidden under the cloak of charity. Even charity becomes a means of subduing the worker.

As to State government relief we merely have to point to the States and cities under Republican administration, from California to Maine, and find that not one single Republican State has made the slightest move toward social insurance and toward unemployment insurance in particular. The Republican Party maintains a bitter opposition. President Hoover has elevated opposition to unemployment insurance to the height of a patriotic duty. He calls unemployment insurance a dole and declares, that a dole is un-American. President Hoover wraps a slap in the face of the workers into an American flag and then demands of the workers to kiss that flag.

In this practice, however, the Republican Party is ably assisted by the Democratic Party.

The Democratic Party is also in power. In the distribution of the balance of the Federal Government we face today the Republican Party in possession of the executive and the Democratic Party in possession of the legislative branch. The Democratic Party controls Congress—the House of Representatives organizationally with an outright majority, the Senate politically with the help of Republican insurgents. Thus we are justified to judge the Democratic Party, too, on the basis of its national record.

The Democratic Party united with Hoover in the relief for the bankers and in the rejection of the principle of unemployment insurance. The Democrats, too, subscribe to the characterization of unemployment insurance as a dole and the dole as un-American.

The International Workers Order, being an organization of workers, many of whom are unemployed, ask themselves, How can unemployment insurance be un-American? Unemployment insurance would secure the workers and their children the necessary food to live, while now they are forced to starve. How can a measure be un-American that secures food for hungry masses?

Millions of American workers and their families are these days ransacking the garbage cans for food. How can it be un-American to pay these workers an insurance to secure them against the miserable necessity of looking for food in the garbage cans? Millions of workers' children are these days suffering from undernourishment, from slow starvation. Their parents are out of work and without income. They cannot provide their children with the indispensables for their lives. How can it be un-American to pay these workers an insurance so that they can feed their children and thereby stop the spectacle of millions of starving children in the richest country on earth?

If Americanism means what it seems to mean for President Hoover, for the Republicans and Democrats, then it must be changed at once. If Americanism is to mean anything for the workers it must mean the principle that the whole of America takes responsibility for the lives of its useful inhabitants and their children. If Americanism does not mean that, the workers cannot consider it worth having; but if it is to mean that, it surely requires the defeat of the Republican and Democratic Parties at the election, because for the Republican and Democratic Parties, Americanism means to help the bankers and to starve the workers.

Neither Republican nor Democratic Parties are against the principle of pensions. They only oppose the principle that workers should receive pensions. They are pensioning Government officials and Army and Navy officers. Surely, if an officer deserves pension, a worker deserves it doubly. Compare their respective services to society ; the result will all be in favor of the workers. The worker does useful and necessary labor for society, the Army officer does not. The worker keeps society alive with his labor. The Army officer learns how to kill off as large parts of society as possible in as short a time as possible. The worker in action constructs buildings, bridges, railways, etc. ; the Army officer in action blows them up and destroys them. So why are pensions to the one a patriotic duty while pensions to the other are declared un-American?

We repeat, if Americansim and patriotism now mean what they seem to mean for the Republicans and Democrats then their meaning must be changed at once. If Americanism is to mean anything for the workers, it must mean that the whole of America takes responsibility for the maintenance of the lives of its most useful inhabitants—the workers and their children. If Americanism and patriotism do not mean that, then the workers cannot consider them worth having.

But if they are to mean that, we surely cannot have them with either Republican or Democratic Parties in power.

The Democratic Party, too, agrees with Hoover that it is not the business of the Federal Government to take care of the unemployed. The Federal relief measures of the Democratic Party took the form of passing of the Hoover Reconstruction Finance Corporation measure, help for the bankers, and, in league with the Republicans, public-works measures which are nothing but pork-barrel legislation. This legislation does not help the workers but increases their difficulties by increasing their tax burden. Republicans and Democrats have a peculiar logic. The masses grow more and more miserable because their income was reduced to almost nothing or stopped entirely. Help is needed, cry Republicans and Democrats; then they go and levy additional taxes on everything the masses need.

The Democratic Party has a plank on social insurance. It says that it stands for unemployment insurance and old-age pensions by State law. But in all the States under democratic control from Alabama to Massachusetts, there has not been as much as a step made toward the one or the other. Would it not be more than naive of the workers to take serious a promise which the promiser had power to make good for years but has not even talked about—until he needed the votes of the workers?

The International Workers Order also considers the immediate payment of the veterans' bonus an imperative necessity. Many of our members are World War veterans. They are largely unemployed. They are entitled to their back pay for services rendered on the battlefields during the war.

Republicans and Democrats unite in refusing this request. Why? They say that the financial situation of the country does not allow such an expenditure. But why was there no hesitation during the war to pay in cash into the pockets of the war profiteers the millions of war profits? Why were the war profits of the capitalist that were pocketed without risk paid in cash and why are the war risks of the soldiers entered into without prospect of profit paid with promises? Why do the capitalists always get theirs and get it cash on delivery; and why are the workers always unable to obtain theirs? When the capitalists need something the Government borrows billions. But the workers' needs are denied on the ground that payment would upset the financial equilibrium of the Government. Other times the workers' needs are denied, because it would be un-American to give anything to the workers.

Surely political parties with such records and such guiding principles cannot expect the support of the workers. Surely workers' organizations like our International Workers Order cannot pledge their support to such political platforms, candidates, and principles.

No, we can certainly not recommend that the members of the International Workers Order endorse the platforms or candidates of either the Republican or the Democratic Party. Our organization is concerned with the interests and lives of the workers. Republican and Democratic Parties are concerned with the business and profit interests of the capitalists. Let the capitalists vote for their parties. We must look for a party of the working class.

The Socialist Party claims to be a party of the working class. But the Socialist Party, too, has set examples in practice which enable us to compare their words with their deeds. We are the more justified to do this as they themselves repeat again and again as their recruiting slogan, "Look at Milwaukee."

Well, we look at Milwaukee. The workers in New York are hungry; so are the workers in Milwaukee hungry. The wages for the workers of Chicago are being cut; so are the wages of the workers in Milwaukee being cut. The unemployed demanding relief are being jailed in Chicago and New York; so are they jailed in Milwaukee. The Democrats in New York and the Republicans in Philadelphia refuse categorically to make the rich capitalist pay for the maintenance of the destitute unemployed workers. So does Socialist Milwaukee refuse categorically to make the rich capitalist pay for the maintenance of the destitute unemployed workers. In the Democratic hell of New York, in the Republican inferno of Philadelphia, and in the Socialist paradise of Milwaukee the workers are forbidden alike to eat the fruits of any tree, except the tree of misery and starvation.

In Democratic New York as in Socialist Milwaukee the police are used not against the bosses who pay starvation wages but against the workers who strike against starvation wages.

The social insurance proposals of the Socialist Party platforms are not dictated by the interests of the workers; they are patterned after the example set by Bismarck. Any social insurance of which the burden or even only part of the burden is borne by the contributions of the workers themselves is merely governmentalizing the present voluntary mutual-aid societies. For the part contribution provided for the bosses the workers are punished by being deprived of the power of administering their funds, once the Government would take over such administration. One can easily figure out what that means in the hands of corrupted political machines, the political principle of which is that helping the bankers is a patriotic duty and helping the workers is un-American.

The Socialist Party claims its concern not only for the workers but also for the capitalists business. When at the convention of the Socialist Party a proposal was made to put into the platform that from the capitalist should be taken, as the capitalist had taken from the people, by expropriation, Norman Thomas, the presidential candidate of the party indignantly declared that he would never run on such a platform. The proposal was rejected.

The Socialist Party evidently denies the obvious truth that we are in a position where we either take from the capitalist to serve the living interests of the workers or to take from the workers to serve the profit interests of the capitalist. The Socialist Party wants to carry water on both shoulders; but the carrying of water on both shoulders is only a trick of political fakers. In reality it cannot be done. And when one tries to make it appear that he does it, he does it only to deceive at least part of his audience.

The plight of the workers results from the private capitalist control of the social means of life. This private control is exercised for profit. It is exercised by big business. Its exercise is the essence of business. Any help given to capitalist business is a contribution to the survival of a condition in which the profit ers will starve the workers for profit. Business, that is, capitalist economy, can only be helped by taking from the workers. The workers can only be helped by taking from big business. Big business and workers are two masters that cannot be served at the same time. Service to the one means struggle against the other. A political party that pretends service to both wants to conceal before the one the fact that it really serves the other. It wants to maintain the legend of the community of interests between the two so as to prevent the workers from fighting the capitalists.

A social-insurance program can be effective only when it is openly an effort to make the capitalist pay for it. The capitalists with their system of profit-making produce mass starvation; they and they alone must be made to pay for the relief. If that means that they have to curtail other expenses, so much the better. Let the politicians steal less of the public money in form of graft; let the Government apparatus be pruned of its nepotism and favorite pay rollers; let the Government stop manufacturing poisoned gases, stop building war tanks and battleships, stop spending hundreds of millions for military purposes, and there will be enough money to feed the hungry workers.

Of all the parties in the field we find the Communist Party to be the only one that concerns itself with the welfare and interests of the masses.

The Communist Party evidences this service to the working class in its program for social insurance. This party recognizes that at this moment of mass unemployment and mass starvation the all overshadowing need of the hour is social insurance. It puts social insurance in the first place of its platform and demands.

The Communist platform also definitely puts the burden of social insurance where it belongs—on the shoulders of the bosses and the Government. It declares as categorically as we could wish that while millions of workers and their children are starving it is the duty of the Government to mobilize its last dollars for relief and for insurance against unemployment. If these dollars are not now in the public treasuries, let them be put there by taking them from the millionaires. If the public treasury is scheduled to use its dollars for other less important purposes, as, for instance, armaments, let these expenditures be stopped and the funds be assigned instead to relief and insurance against unemployment.

In these demands it puts the interests of the workers forward as its sole concern. In this the Communist Party differs fundamentally from all other parties. The Republican and Democratic Parties openly serve only capital. The Socialist Party serves capital and speaks for labor.

In looking for a party whose program deserves the support of a workers' organization like the International Workers Order, and whose activities deserve the confidence of the workers, we come to the conclusion that only the Communist Party fills the requirements. The fact, that the capitalist, through their Republican and Democratic Parties and with the active help of the

Socialist Party (as in California) try to keep the Communist Party off the ballot is another reason why we should support it and have confidence in it. If the forces that are today keeping in misery millions of the most useful masses in the country unite their hatred, opposition, and persecution against a political party that speaks for the hungry masses, it must be because they fear that party. And we of the International Workers Order, representing the interests of the tens of thousands of our members, and, in a larger sense, also representing the interests of the class from which our membership is mainly recruited, have all reasons to support the party which is feared by our enemies, the profiteers and their politicians.

In our work, and in our efforts to solve the problems of our members, which are the problems of the working class, we find the need of workers' unity. It is useless to point to the relief for the masses of unemployed as a social duty if we did not also endeavor to establish workers, unity as a measure to force society to discharge this duty.

The International Workers Order stands for and practices in its organization the unity of black and white worker as a necessary prerequisite of successful workers action. The Communist Party fights for this unity. All other parties are against it. Republican, Democratic, and Socialistic Parties sing the praises of the Constitution of the United States and preach constitutional methods of political struggle. But all unite to make and to keep the thirteenth, fourteenth, and fifteenth amendment of the Constitution a farce.

Republican, Democratic, and Socialist Parties, are united on the principle of protecting the native-born against the foreign-born worker. Our experience has taught us that politically the workers need no protection against each other—what they need is protection against the profit makers. The measures of "protection" of the native against the foreign-born worker are only measures to set one section of the workers against the other. These measures are designed to make believe that the plight of the native-born worker is caused not by capitalist exploitation but by the presence of the foreign-born worker. At the same time the laws against the foreign-born worker rob the latter of all rights and privileges. They make it a crime for him to organize and fight for better working conditions. The foreign-born worker is thus made the helpless object of wage-cuts, of yellow-dog contracts, and other measures to reduce wages and increase profits. With the foreign-born worker forced into helpless submission to the bosses' dictates, the native-born workers' resistance to these dictates is half defeated before it begins. Thus the laws against the foreign-born worker, pretended as measures to help the native-born worker, in reality are intended and react against the native-born worker, against the whole working class.

The International Workers Order advises its members and friends to fight against this policy of anti-alien laws; they must protest against the deportation practices of the Labor Department in Washington. These practices and laws are directed against the working class, against our members. They weaken us in our struggle for social insurance. Instead of uniting the workers for action on their own behalf, they divide them on behalf of the interests of the capitalists.

The position of the worker now is that he cannot work without the permission of the capitalist. And since the worker must work to earn a living, the withholding of the capitalists' permission to work means that the capitalists command the workers to starve. The measures against different sections of the working class, the laws against the Negro masses, robbing them of their rights, the laws against the foreign-born workers, robbing them of theirs, tend to make it a crime for the worker to resist the command of the capitalists to starve. Against these conditions only the program of the Communist Party proposes effective measures. Against these conditions only the activities of the Communist Party struggle.

For these reasons we propose to the members and to the friends of the International Workers Order to support the platform, to vote for the candidates, and to help in the election campaign of the Communist Party.

Social insurance is the imperative need of the hour.

A vote for William Z. Foster for president and for James W. Ford for vice president, a vote for the Communist candidates and platform is a vote expressing determination to fight for social insurance and to support a party that leads the fight for social insurance.

Members of the International Workers Order, unite your political strength on the basis of the principles of our organization: for social insurance. On the basis of our common interest let us unite our political action in this election campaign with all the workers, native and foreign born, black and white, under the leadership of the Communist Party.

Senator DONNELL. The closing portion reads as follows:

> Social insurance is the imperative need of the hour.
>
> A vote for William Z. Foster for President and for James W. Ford for Vice President. * * *

I pause to ask you if you know who James W. Ford is?

Mr. RYMER. I have heard of him.

Senator DONNELL. Is he a member of the Communist Party?

Mr. RYMER. As far as I know.

Senator DONNELL. You know he is?

Mr. RYMER. I have heard.

Senator DONNELL. You never made a legal investigation, but you have heard that?

Mr. RYMER. Yes, sir.

Senator DONNELL. I will repeat—

> A vote for William Z. Foster for President and for James W. Ford for Vice President, a vote for the Communist candidates and platform, is a vote expressing determination to fight for social insurance and to support a party that leads the fight for social insurance.
>
> Members of the International Workers Order, unite your political strength on the basis of the principles of our organization: For social insurance. On the basis of our common interests let us unite our political action in this election campaign with all the workers, native and foreign-born, black and white, under the leadership of the Communist Party.

Then, in big black type, "Vote Communist." Have you ever seen one of these publications before?

Mr. RYMER. No, sir.

Senator DONNELL. It is issued by the campaign committee of the International Workers Order, August 1932, and has a union designation immediately below that statement. You see that, don't you?

Mr. RYMER. Yes, sir.

Senator DONNELL. Now, as a matter of fact, you know, do you not—whether you have made a detailed legal examination into the evidence—you know that the International Workers Order works hand and glove with the Communist organization and its officers and has been interlocked, interrelated, and very closely affiliated for many years?

Mr. RYMER. I don't know that, sir. I don't think it is relevant to the discussion of this bill. I am trying to be patient and am trying to answer all your questions, but, frankly, it isn't helping to discuss the bill at all. In fact I think it is helping to confuse the issue very much.

Senator DONNELL. Mr. Rymer, we thank you for your comment on that. I am interested in the connection of the International Workers Order to the Communist Party.

Mr. RYMER. I am trying to answer to the limit of my knowledge.

Senator DONNELL. You know as a matter of general knowledge that the International Workers Order and the Communist Party are closely affiliated and have been for years?

Mr. RYMER. I don't know that, sir, and it is not so. I don't see how it regards legislation that is about to be passed that has the welfare of the people. Just because one publication might have been issued and might have been misunderstood——

Senator DONNELL. We will come to some more along the same line. But before I leave this one section, I want to read another sentence which appears just above what I read:

> For these reasons we propose to the members and to the friends of the International Workers Order to support the platform, to vote for the candidates, and to help in the election campaign of the Communist Party.

Do you see that sentence?

Mr. RYMER. Yes, sir. It is issued by a campaign committee of individuals, I presume, and I interpret from that they must be interested in supporting these candidates. It is not issued by the International Workers Order.

Senator DONNELL. I observe this language: "Issued by the campaign committee of the International Workers Order." Do you mean to tell us here today that this International Workers Order did not get out that particular publication and pay for it?

Mr. RYMER. That would be my interpretation, sir.

Senator DONNELL. What?

Mr. RYMER. The last statement you made.

Senator DONNELL. Is correct?

Mr. RYMER. That was not published by the International Workers Order.

Senator DONNELL. That is the conclusion you draw from the language: "Issued by the campaign committee of the International Workers Order"?

Mr. RYMER. Yes, sir.

Senator DONNELL. Mr. Rymer, now I understand you are in disagreement with me as to the relevancy of this, but are you in position to get for us the information and furnish to the clerk of this committee as to who paid for that particular publication?

Mr. RYMER. I could try. I won't say I can.

Senator DONNELL. If you try, will you send it to the clerk of this committee? We would appreciate it very much.

Now, I would like to call attention to another one here and ask you whether or not there is such organization as the national executive committee of the International Workers Order; do you know?

Mr. RYMER. Yes.

Senator DONNELL. You refer to this order as having been founded in 1930.

Mr. RYMER. Yes.

Senator DONNELL. I have here a publication, "A New Workers' Stronghold. What is the International Workers' Order, and why every worker should join it." That is what it says on the front of it. And also it says: "Issued by National Executive Committee, International Workers' Order, New York, 1930." Do you draw the conclusion from that as you did from the other that it is not issued by the International Workers Order?

Mr. RYMER. No—doesn't sound it.

Senator DONNELL. You think this one is?

Mr. RYMER. Undoubtedly.

Senator DONNELL. Why don't you think the campaign committee of the International Workers Order is?

Mr. RYMER. It sounds to me as if individuals, who might have been members of the International Workers Order, got together on their own and set up such a committee.

Senator DONNELL. I would like to have you look at this copy here, Mr. Rymer, of another document which bears on the front of it these words: "Issued by the campaign committee of the International Workers Order, August 1932," which is entitled on the front page of it: "We support the Communist Candidate in this year's election. Every Member of the International Workers Order must rally behind the Communist election platform." Do you observe that?

Mr. RYMER. Yes.

Senator DONNELL. Do you think this particular booklet, likewise dated August 1932, was not put out by the International Workers Order?

Mr. RYMER. That would be my interpretation.

Senator DONNELL. That is your interpretation—not put out by it?

Mr. RYMER. Yes, sir.

Senator DONNELL. I will also ask that this publication be set forth in the record of this proceeding.

(The document referred to follows:)

WE SUPPORT THE COMMUNIST CANDIDATE IN THIS YEAR'S ELECTION—EVERY MEMBER OF THE INTERNATIONAL WORKERS ORDER MUST RALLY BEHIND THE COMMUNIST ELECTION PLATFORM

(Issued by the Campaign Committee of the International Workers Order
August 1932)

Comrades and fellow workers, the election campaign is on. The various political parties are beginning to approach the voters. You will be asked to support one or the other party. You have to make up your mind as to where you stand.

In order to do that you must make clear to yourself what is best for you at the present time. This is the time of the most severe economic crisis in the history of this country and the world. Industrial production has been cut to nearly one-half. Steel production has been cut to nearly one-tenth of its capacity. Automobile production is below one-half of the standard of 1929. Exports and imports have been cut accordingly. Bank failures involving millions of small investors are the order of the day. The masses of the farmers are unable to eke out even a miserable living. But worst of all is the situation of the workers. Nearly 15,000,000 are out of work altogether. Other millions work 2 or 3 days a week at greatly reduced wages. Wages have been cut repeatedly and most workers hardly get one-half of what they got in 1928 or 1929. The situation is becoming worse every month. The crisis is deepening, and there is no prospect for improvement as the crisis is world-wide.

Industry, agriculture, and commerce have been affected by the crisis, but while thousands of factories are closed down and numerous businesses find themselves in a bad plight, the businessmen themselves, except for some of the smallest, are not suffering starvation. Most of the manufacturers and bankers still enjoy a luxurious living. Even the middle class has enough comfort. And while the petty businessmen and the petty trader have been severely hit by the crisis, it is the workingman that is suffering most. The working masses have nothing to live on. Hundreds of thousands are starving to death. Thousands have actually died of starvation. Disease is rampant among the unemployed. Suicides are on the increase. Hundreds of thousands of families all over the country are being evicted from their homes for nonpayment of rent. Hundreds of thousands are roaming the streets with no prospect of relief. The miserable city and county relief given as charity to the needy families is like a drop in the ocean of misery and starvation. Besides, there is discrimination even in this paltry aid, and only the "deserving" ones get the $1 or so a week.

Under such conditions, what has to be done to relieve distress? What has to be done to save the lives of millions upon millions of toilers who, with their labor and skill, have created all the wealth of this country and who are now left to die of hunger? In which way shall real relief be achieved? This is the most burning question of the day. This is the question which overshadows all others. This is a vastly more important question than winning a war in an armed conflict. For no enemy invasion could ever bring as much misery to the masses of the people as the crisis has already brought in the course of 3 years. This is a more important question than saving the country from a dangerous epidemic. For no epidemic ever caused so much havoc in modern times as did the crisis.

What should be done to relieve the sufferings of millions? How shall it be done? By the answer to this question you can test the various parties which are appealing for your support. This question should be uppermost in your mind.

The toiling masses must force the Government of the United States to give relief for the unemployed directly and to introduce unemployment insurance. The masses must achieve this by concerted mass action. They must fight for their right to live. They must do it under the leadership of a strong organized body. This is the working-class answer to the unemployment question.

This country is rich. The workers have created enormous wealth which is now held by the manufacturers, landlords, and bankers. Part of this wealth should be returned to the workers. This crisis was not caused by the workers. The workers are willing to work, to create, to provide the entire population with food, clothing, and shelter. The crisis came about as a result of the inane capitalist system. The crisis is due chiefly to "overproduction," which under the capitalist system is another name for underconsumption. Under the capitalist system, the working masses forming the major part of the market for commodities do not receive a sufficient compensation for their labor to be able to purchase the great amounts of goods which are thrown into the market by mass production with the aid of modern technique. The crisis means hunger amongst riches, stagnation of production due to immense production capacity. It is a return to primitive conditions due to the development of the most modern means of production. It is an insane situation. Men starving because they have produced too much. A country in the grip of hunger due to an overabundance of food. This madness is capitalism. Capitalism is a system whereby the means of production—the land, the factories, the mines, the farms—are in the hands of private owners who operate them not for public use but for private profits. As soon as they see that they cannot get enough profits they shut down "their" concerns. They do not care for the masses of the people. They care for their own riches. They shut down their businesses and wait for better times. Meantime they enjoy life in the summer resorts, in the wealthy clubs, or they travel abroad while the real creators of all their wealth are digging in garbage cans for a miserable food remnant and mothers are throwing their children out of the windows to jump after them to death out of sheer misery due to starvation.

This must not be. The lives of the masses must be the prime concern of all the toilers. These lives can be saved and made bearable if pressure enough is exerted on the master class and its government to force them to disgorge part of the wealth taken away from the workers. This, however, cannot be done by mere persuasion. It cannot be done by begging humbly. It cannot be done by appeals to humanitarian feelings. It must be done by revolutionary methods—which means by uniting in a huge mass movement and attacking the master class on every occasion.

It is a simple issue. Shall the capitalists continue to keep their billions while the masses are dying or shall they be forced to give up a part of their wealth so that the masses may live? This year the Reconstruction Finance Corporation of President Hoover was authorized to give about $4,000,000,000 to bankers and railroads and for public buildings and other such projects. The money was supposed to help create jobs for the unemployed. No jobs were created. Unemployment kept on increasing, while a few railroad magnates and bankers were helped (among them General Dawes who got away with a gift of $80,000,000. If those four billion were distributed among 1,000,000 unemployed, each one would receive $400 which would help them overcome their hunger for a while. If all the 15,000,000 unemployed were to receive a minimum of $12 a week it would amount to $9,000,000,000 a year. This country can easily raise that amount. It is rich enough. But if this were accomplished, the capitalists would be so much poorer. The masses would not starve. Millions of lives would be saved. But the capitalists would lose part of the wealth they own. This they refuse to do. They would rather see the masses starve than part with some of the riches the masses have created in the sweat of their brow. Since they do not want to part with it of their own acocrd, they must be forced to do so. They must be forced by the workers.

This is the central problem of the day. And this, for you, should be the acid test in judging the various political parties. You have to ask yourselves, Is this or that party in favor of mass action to force the capitalists to yield part of their riches in favor of the unemployed?

The party that not only advocates but also leads the struggle for unemployment relief and unemployment insurance is your party and should be supported by the members and branches of the International Workers Order. The party that only pays lip service to this demand because it is popular among the masses, but in reality doesn't even think of leading the masses into revolutionary struggle for these demands, is not your party. No matter how high sounding its phraseology may be, it is not a party of the workers but of the capitalists.

In the American political field there is only one party that can be characterized as the party of struggle for the interests of the workers and that is the Communist Party. The other three parties are open or disguised capitalist parties. The Republican Party did not even mention unemployment relief in its platform. The Republican Party condones the wage cuts and all the other appressive measures of the Hoover administration. The Republican Party is the party of Wall Street and there must be little doubt in the minds of the workers that this party is an agent of their exploiters. But the same holds true about the Democratic Party. Being in the minority and wishing to utilize the mass dissatisfaction with the Republican Party, it has put a number of radical phrases into its platform. It has mentioned the unemployed. So did the Democratic candidate Roosevelt. But in reality the Democratic Party is opposed to unemployment relief and unemployment insurance. The Democratic platform speaks about "old age and unemployment insurance, under State laws," which means that the Democrats do not even propose to introduce Federal unemployment insurance but leave it to the various States to do as they please. As for the Socialist Party, it uses a lot more radical phrases. It accuses, not the Republican administration alone, but capitalism as a whole, it advocates unemployment insurance to be introduced by the Federal Government, but it leaves the matter to the mercy of the capitalists and their politicians.

The Socialist Party is in reality against the workers' struggle for social insurance and unemployment relief. The Socialist Party is afraid of workers' mass struggles. The Socialist Party has put obstacles into the path of the workers fighting for bread. When a hunger march was conducted last December to Washington to demand unemployment insurance, the Socialist Party branded it as a "Communist publicity stunt." When hunger marches are organized in the various States, they meet with the most stubborn opposition from the Socialist Party. Where the Socialists from the city administration, as in the case in Milwaukee, Wis., and Reading, Pa., the Socialists not only have failed to introduce unemployment insurance but they actually use police force to club and disperse working masses demonstrating in favor of relief.

The Socialist Party is a party of peace with capitalism. It advocates certain liberal reforms which can find place in any liberal platform, but it advocates peaceful cooperation with the capitalists and their agents. Not only in respect to social insurance and unemployment insurance but in every other respect the Socialists are demanding a better capitalism, whereas the Communist Party is advocating the destruction of the capitalist system by a mass upheaval of workers and poor farmers and the establishment of a workers' and farmers' government.

Here, too, you have an acid test. The party that is not afraid to hurt capitalism, the party that is leading the masses to deal capitalism one blow after another in order to weaken it and to increase the power of the workers that they may be ready to overthrow capitalism when the opportune time comes is your party; the party that is afraid of hurting capitalism but is advocating cooperation with the capitalists and introducing reforms which are only meant to strengthen capitalism is not your party. It is a party of capitalism. It may call itself radical or socialist. It is nothing but a party of Wall Street. In the very same way as the Democrats' opposition to the Hoover regime does not make them opponents of Wall Street but rather servants of Wall Street ready to improve its business by more efficient methods, so is the opposition of the Socialist Party to capitalism nothing but a verbal opposition behind which you find people ready to cooperate with the capitalists in every possible way and thus improve the position of Wall Street.

Unemployment relief and unemployment insurance is not the only demand put forth by the Communist Party in the present election campaign. Its platform contains a number of other points of tremendous importance for the toiling masses. The Communist Party is against the Hoover wage-cut policy; it is for adequate relief for the poor farmers; it is for complete political, economic, and social equality for the Negroes and for self-determination for the Black Belt; it is against the terror policy including deportation of foreign-born workers; it is for the defense of the Chinese people attacked by Japanese imperialism; it is against imperialist war now being hatched by imperialist powers and for the defense of the Soviet Union, the only country where the workers are actually free, where they are their own masters, where there is no unemployment and where the masses, under the leadership of the Communist Party, have laid the foundation for a society of equality, security, and cultural living for all.

These demands touch the very heart of the situation of the masses at the present times. The capitalists are making the situation of the employed workers worse day by day by cutting their wages, by introducing the speed-up system and by worsening working conditions. The three capitalist parties have practically agreed to the cutting of wages. All they ask is an extension of the stagger system whereby each worker should be employed part of the time so that all would be unable to make a living. The Communist Party is against such a policy. The Communist Party calls upon the workers to resist wage cuts and to better conditions even if this may hurt the capitalists. The Communist Party has been instrumental in conducting many strikes where the workers met with the resistance of leaders and functionaries of the American Federation of Labor aided and supported by the Socialists union leaders. This fact should prove to you once more that the Socialists are agents of capitalism while the Communists are flesh and blood of the working class, fighting its struggles.

The necessity of immediate relief for the farmers who are being strangled by the banks, the railroads, and the manufacturers, and who are suffering from the crisis to an extent that millions of farms are bankrupt but cannot be sold because there is no buyer, need not be explained at length. A word or two, however, must be said about the Negroes. Negro inequality is fostered by the capitalists, their press, their government, their judges, and their priests as a means of splitting the working class. By terrorizing the Negro masses through lynching murders, by treating the Negroes as inferiors who have no right to the same position as the whites, the capitalists strive to break the ranks of the workers. Divide and rule is their slogan. In order to be able to resist the capitalist attacks, in order to be able to launch an offensive against the capitalists, there must be unity between all sections of the working class—unity not in words only but in action. Such unity has been introduced by the Communist Party which is the only political party in this country not only fighting for complete Negro equality but also practicing such equality within its own ranks. Negroes in the Communist Party feel absolutely at home. They are given leading positions. They often lead the white workers. The Vice Presidential candidate of the Communist Party, Comrade James W. Ford, is a Negro worker. The Communist Party is not a philanthropic organization. It is a political party. It recognizes that only when there is full equality of the workers of every race and origin can there be an effective united front against capitalism. It recognizes that in the Black Belt in the South where the Negroes form a majority of the population, they have a right to form their own Negro government and that all the workers of this country ought to fight to secure for them this right of self-determination.

Self-determination for the Negroes in the Black Belt is also one of the tests you as workers can put up to the various political parties in this country. Are they or are they not for real full and unconditioned equality for the Negroes? Aren't they only giving lip service to the idea of Negro freedom? If you think out the idea of Negro freedom to its logical conclusions you will realize that the freedom means also the right for the Negroes to form a separate Negro state and to rule themselves independently. Real freedom for the Negroes means that they will not have to take orders from white-ruled state. Negro freedom means that by ruling themselves the Negro masses may feel that they are really equal to anybody else.

Now we know fully well that the white masters want to keep the Negroes in subjugation. It is in the interests of the white capitalists to have millions of black workers still more oppressed than their white brothers. It is in the interests of the capitalists to imbue the white workers with hatred and contempt for the Negro workers in order to keep them from forming a united front against their oppressors. It is in the interests of the few Negro capitalists to curry favor with the white capitalists at the expense of the toiling masses, black and white, in order that they, the black capitalists, may be allowed a few crumbs from the table of the white masters. And it is in the interests of the workers both white and colored to stand together as one class army against the class of the oppressors.

The Republican Party is the party of oppression. The Democratic Party is the party of oppression. The Socialist Party is the party that caters to the oppressors and that has actually established a Jim Crow rule within its own ranks. The Socialist Party mumbles something about Negro rights, but it does not stand for equality of the Negroes. It speaks liberal words against lynchings but it does not put up a vigorous struggle of both Negro and white workers against the lynchers and their bloody lynch system. It repudiates self-determination. The only party that stands for absolute Negro freedom and that puts up a fight for that freedom is the Communist Party.

Police terror has been felt too strongly by the members of the International Workers Order to need further emphasis. Strikes are being broken by police intereference. Strikers are being arrested. Strike areas are being declared under martial law. Picket lines are broken by State troopers, national guards, and hired thugs. Foreign-born workers are being arrested and deported by the tens of thousands. During 1931 alone nearly 20,000 were deported. Under the Dies bill every worker who is dissatisfied with his boss would be liable to deportation. Police terror is a direct menace to the members of the International Workers Order.

Many members of the International Workers Order are foreign born. This did not prevent them from building up this country. It did not prevent them from being one of the most active sections of the American working class. It does not prevent them from wishing to see a different America, an America where the workers are actually free. It does not prevent them from making sacrifices for the sake of changing America into a really free land. But because they do so, the masters have become frightened. The masters wish to get rid of those very workers who for decades have toiled to create for them billions of dollars. The deportation policy is rampant. The idea is to divide the workers, to create a barrier of prejudice and hatred between the native workers and the foreign workers. Aside from wishing to get rid of the militant foreign-born workers, aside from trying to terrorize the remaining foreign-born workers in order to keep them from fighting the bosses, the rulers of this country are trying to spread among the native workers an American nationalism, a false pride in their "Americanism." This, they expect, will prevent the workers from protesting against the bloody work of American imperialism in Latin America, China, and other countres.

It is up to the workers, both native and foreign born, to resist this assault upon the foreign born. It is in the interests of all the workers to retain their united front unbroken and to strengthen it by adding hundreds of thousands and millions of workers of every color, race, and origin. You, members of the International Workers Order, ought to ask yourselves: Which party is actually fighting discrimination against the foreign born? Which party is fighting against deportations? Which party is fighting imperialism? You will soon realize that the Communist Party is the only one that has put up a stiff fight against all these policies of the Government and its agents. The Communist Party does not waste liberal words about the badness of "intolerance," the way the Socialist Party does. The Communist Party is leading a mass fight against the attacks upon the foreign born and upon other peoples. By its actions you can recognize the Communist Party.

No less a real menace is the menace of war. Behind all the peace talks of the imperialist governments, behind their proposals of "disarmament" which mean disarmament for the other countries and increased armaments for those who make the proposals, plans are being perfected for a new world war. The capitalists realize that a world war would be a way out of the crisis for the victors. By means of a new slaughter they hope, first, to stem the rising tide of revolutionary discontent; second, to improve their business through war orders; third, to secure new slices of the globe which is all divided among the major imperialist robbers. The biggest slice they expect from destroying the Union of Soviet Socialist Republics. And while the imperialist powers are preparing for war aaginst each other they are still capable of sinking their differences for a while in order to form a united front against the Soviet Union as they did behind the Japanese attack on Manchuria and when the Japanese advanced to the Soviet border. The workers must fight these war plans of their masters.

The fight for Negro rights, the fight against police terror, the fight against the war danger, and the fight for the defense of the Soviet Union are not contained in the platforms of the three capitalist parties. They are contained only in the platform of the Communist Party. And they are no mere demand on paper; they are the subject of the daily struggles of the Communist Party and all organizations under its guidance.

One word about the American Federation of Labor. Most of you are workers. Many of you belong to labor unions, among them also to unions affiliated with the American Federation of Labor. You will be appealed to by the officers of the various unions to vote for one or the other candidate of the three capitalist parties. You will know better. You will not be surprised at the union chiefs appealing to you to vote in a manner that will de detrimental to the working class. We know the nature of these chiefs from our bitter experience. For haven't they given up the class struggle? Haven't they repeatedly given their consent to wage cuts? Haven't they worked hand in glove with the bosses against the workers wherever the latter revolted demanding higher wages or a stop to the wage cuts? Haven't the workers been faced with the treachery of their union leaders in the coal mines of Kentucky, Illinois, and Ohio; in the textile mills of New England and North Carolina; in the clothing industry of New York, Chicago, Rochester, and many other cities; and in every other instance wherever the workers united to offer resistance to their bosses? It is only in keeping with their general policy of cooperation with capitalism that these misleaders of labor are urging you to support those who are fighting against your interests in the political field.

It is for this reason that the national executive committee of the International Workers Order has endorsed the candidates of the Communist Party and is hereby appealing to the members of the International Workers Order to support the Communist Party in the election campaign and at the polls next November.

To support the Communist Party at the election campaign means not only to frequent the election mass meetings, to distribute the election literature of the Communist Party, and to make converts to the platform of the party, but mainly to participate in all the struggles led by the Communist Party for the realization of its platform. Unlike the three capitalist parties, the Communist Party does not rely on the vote and parliamentary action alone to achieve its aims. True, it solicits votes and would be glad to get its candidates elected to the Federal and State legislatures, but its main reliance is on mass action of the workers. Its very representatives in the legislatures are to be used to help organize and consolidate the workers mass action against capitalism. The Communist Party will use the platform of Congress or city or State assembly to appeal to the workers, to expose the exploiters, to help the workers better to understand the political situation and to facilitate their attacks on capitalism. The Communist Party is the only party which combines parliamentary and nonparliamentary methods in one great class struggle of the workers for the improvement of their conditions at present, for making the capitalists bear the burden of the crisis and for ultimately abolishing capitalism and introducting a soviet system.

The Union of Socialist Soviet Republics must also be a means to test the various parties. Has Hoover endorsed the Soviet Republic? Has Roosevelt endorsed the Soviet Republic? Has Thomas endorsed the Soviet Republic? None of them has done so. None of them actually is in favor of the Soviet Union no matter how their words may differ. Why are they against the Soviet Union? Because they are in favor of capitalism. Capitalism and sovietism are opposite poles. Under capitalism, power is in the hands of the owners of wealth; under sovietism power is in the hands of the workers led by the Communist Party. Under capitalism the masses are exploited by a few rich, and poverty, misery, and unemployment are inevitable; under sovietism there is no exploitation of man by man, there is no unemployment, and man's labor is building up a new life where there will be comfort and culture for all. Under capitalism the world is a mire of blood and tears, the blood of toilers squeezed out of them to make riches for their masters, the blood of millions of soldiers driven to slaughter to secure profits for their masters, the blood and the tears of hundreds of millions unable to secure a bare means of subsistence; under sovietism the world is full of constructive work, full of unceasing improvements, full of learning by the masses, full of creativeness, full of a feeling of elation caused by awakening to new achievements and new life.

This is exactly why the three parties of capitalism, bound up and interwoven with this system, hate and combat the Soviet Union under every possible pretext. And this is why you, as members of the International Workers Order, ought to support the Communist Party, which is the only party that stands four-square back of the Soviet Union and that is trying to organize and lead the workers in a manner that will bring about the workers' rule also in this country.

You, as members of the International Workers Order, must especially line up behind the Communist platform for the interests of your own organization. We are a fraternal organization. We are paying sick benefits and death benefits. The more the workers secure by their struggle in the way of unemployment insurance and social insurance, the less will be the burden upon our organization and the better will it flourish. The more we curb the brutal attacks of the police on our Negro brothers and on workers generally, the better for our organization. The more we force the capitalists to abstain from their war preparations and the more vigorously we defend our common Socialist fatherland, the better for the International Workers Order as a fraternal organization.

It is for all these reasons that we appeal to you.

Rally behind the platform of the Communist Party!

Join the struggles for the platform demands of the Communist Party!

Vote for the Communist Party at the November elections!

JOIN THE INTERNATIONAL WORKERS ORDER!

Fill out the following application and send direct to the national office:

Name________________________________ City and State________________________

Address______________________________ Occupation________________Age_______

INTERNATIONAL WORKERS ORDER, 80 FIFTH AVENUE, NEW YORK

Senator Donnell. Now, Mr. Rymer, I call your attention to the concluding four sentences, very brief, of this last mentioned publication, which read as follows:

> It is for all these reasons that we appeal to you:
>
> Rally behind the platform of the Communist Party!
>
> Join the struggles for the platform-demands of the Communist Party!
>
> Vote for the Communist Party at the November elections!

On the back of it—

> Join the International Workers Order! Fill out the following application and send direct to the national office.

Then there is a place to fill in name, address, city and State, occupation and age. Underneath that is found: "International Workers Order, 80 Fifth Avenue, New York." Does that advertisement on the back of the booklet change your opinion at all as to whether this booklet was issued by the International Workers Order or by some individual?

Mr. Rymer. No, sir.

Senator Donnell. Does not?

Mr. Rymer. No, sir.

Senator Donnell. You still maintain it is issued just by individuals?

Mr. Rymer. Yes, sir.

Senator Donnell. You think the advertisement on the reverse side was likewise put out by individuals and not by the International Workers Order?

Mr. Rymer. I think so.

Senator Donnell. And although the name "International Workers Order" appears at the bottom of the advertisement?

Mr. Rymer. It is just a means of advertising.

Senator Donnell. 80 Fifth Avenue, New York—down at the bottom in black type. You still take the view that in your judgment this particular publication that I have presented here likewise was put out, not by the International Workers Order but by individuals?

Mr. Rymer. I do, sir.

Senator Pepper. Will you let the record show that the two documents identified by the chairman are the documents published in 1932?

Senator DONNELL. That has been mentioned and will be so shown. I also ask you whether or not there is a certain document issued to your knowledge in May of 1936 known as the Manual of the International Workers Order. Carrying this on down over a period of years, Mr. Rymer, did you ever see that document issued by the national executive committee of the International Workers Order?

Mr. RYMER. I might have, sir.

Senator DONNELL. Well, it gives among other things certain chapters among which is "Membership and benefits," and also among others is this particular portion of chapter VII—I quote:

> SOCIAL INSURANCE CAMPAIGN
>
> One of the campaigns that must never be lost sight of in the IWO is the campaign for unemployment and social insurance. We must make continuous efforts to build an ever-larger united front of workers, particularly of workers in fraternal organizations, for actions around the passage of a bill providing genuine social insurance. (Visit lodges of other organizations to get endorsements, organize delegations to legislators, etc.)
>
> The campaign for social insurance must be reflected in all our activity, in educational work, in the membership camgaigns, etc.

Mr. RYMER. That proves the statement that I made before.

Senator DONNELL. That you have——

Mr. RYMER. Been active in social legislation for years.

Senator DONNELL. This particular document, do you think it was issued by the International Workers Order?

Mr. RYMER. It is issued by the Order.

Senator DONNELL. It doesn't seem to be signed.

Mr. RYMER. National executive committee of the International Workers Order.

Senator DONNELL. I don't have that in front of me but it is typed down here. Here is another copy—"Issued by the national executive committee, IWO, 80 Fifth Avenue, New York City, May 1936." Are you familiar with the issue of any publication which contained a series of statements from labor leaders and liberals hailing the growth of the IWO?

Mr. RYMER. There have been many.

Senator DONNELL. Let me read you from Harry Bridges. Was Harry Bridges connected with the Communist Party, do you know?

Mr. RYMER. Not that I know of.

Senator DONNELL. Not that you know of?

Mr. RYMER. Yes.

Senator DONNELL. Is he connected with the International Longshoremen's Association?

Mr. RYMER. I have heard that.

Senator DONNELL. You know he was president of that. I quote——

> (Because Mr. Bridges was "busy with negotiations with speaking engagements and other duties" his well wishes are transmitted for him by his secretary, Nellie Walsh, "for the president.")
>
> He sends you his every best wish and sincerely thanks you for your interest and support to the 40,000 striking maritime workers on the Pacific coast.

That is dated February 1937. I also call your attention to this language on another portion of that page. This document, by the way, is entitled "Progressive America Greets us. Statements from Labor Leaders and Liberals Hailing Growth of IWO." And this particular quotation is as follows. It is by Earl Browder, general secretary, Communist Party.

> The Communist Party extends fraternal greetings to the International Workers Order on the completion of its 10 weeks' membership drive which brought in 37,000 new members. This success is not only a tribute to the IWO but is a victory for the entire working class whose interests your organization never loses sight of.
>
> In my opinion, the IWO has been so successful because it pursues a consistent twofold course. On the one hand it follows the most progressive fraternal policies and gives the most benefits to its membership; and on the other hand it takes part in every progressive working-class struggle, striving constantly to meet and win the needs and demands of the workers.

Senator DONNELL. Did you ever see that endorsement by Earl Browder, general secretary of the Communist Party?

Mr. RYMER. No.

Senator DONNELL. Are you familiar with a publication known as the Fraternal News?

Mr. RYMER. I think I have seen it.

Senator DONNELL. You think you have seen it. I call your attention to the issue of April 1940, in which a statement is issued here by Mr. Max Bedacht, the general secretary. He was the general secretary at that time, was he not?

Mr. RYMER. Yes.

Senator DONNELL. And you don't know what his connection was at that time with the Communist Party, if any?

Mr. RYMER. No, sir.

Senator DONNELL. You do not. The statement starts out by saying:

> The International Workers Order is a fraternal benefit society. It operates under a charter issued by the Insurance Department of the State of New York. * * *

I call your attention to another document here, being a souvenir program issued at a special meeting in honor of Rockwell Kent to celebrate his election as vice president of the International Workers Order and the publication of his autobiography—Sunday evening, January 19, 1941. You remember that particular gathering, do you?

Mr. RYMER. I don't, sir.

Senator DONNELL. You do not remember?

Mr. RYMER. I am more interested in the hearings on the health bill.

Senator DONNELL. I understand your interest, but I am asking you some questions in regard to this other matter.

Mr. RYMER. Yes.

Senator DONNELL. You are aware Mr. Kent is a member of the Communist Party, are you not?

Mr. RYMER. No; I am not.

Senator DONNELL. You don't know that at all. Mr. Rymer, I call your attention to a certain letter signed by Max Bedacht, general secretary, as of December 18, 1942, addressed to the lodges of the IWO in certain States. I am quoting:

> Beginning with the issue of Friday, December 18, the Daily Worker will regularly feature an IWO column prepared by us. A copy of the first issue with this column has been sent to you. * * *"
>
> To give us the best possible value the Daily Worker should be read by the largest possible number of members of the order.

Now, that Daily Worker is the same publication, is it not, to which we referred a little while ago, and as a matter of general knowledge, at any rate, you indicated at any rate, that is connected with the Communist organization?

Mr. RYMER. Yes.

Senator DONNELL. You know reflects the opinion of the Communist organization?

Mr. RYMER. Yes.

Senator DONNELL. I call attention also to an excerpt from the Daily Worker of May 25, 1943, in which there is an article entitled "Bedacht Backs 'Daily' Financial Conference." It starts by saying:

> Hearty endorsement of a special conference on Daily Worker and the Worker finances and circulation was made yesterday by Max Bedacht, general secretary of the International Workers Order.

Then a little bit farther down, at the bottom of what I have quoted, there appears in a box—I don't mean that it is part of the article. It is a separate notice.

> NOTICE.—Communist Party branches that have not yet chosen delegates to the Daily Worker's council will choose representatives tonight so that they may be represented at the council meeting Thursday at 8 p. m. at Webster Hall. Alan Max, representing the editorial board, will be the main speaker.

Now, Mr. Rymer, you know as a matter of fact, do you not, that throughout the entire history of the International Workers Order there has been a close identity between its officers—its leaders, such as Mr. Bedacht and Mr. Kent and others—with the Communist Party. You know that to be a fact?

Mr. RYMER. I don't know that, sir.

Senator DONNELL. It isn't a fact?

Mr. RYMER. I don't know that, sir.

Senator DONNELL. You say it is not a fact or don't you know?

Mr. RYMER. I don't know.

Senator DONNELL. You just don't know. Have you ever heard anything like that?

Mr. RYMER. Each one of these men and his relation to a political party—we don't discuss that at our meetings.

Senator DONNELL. How do you account for this advertisement:

> * * * the Taft "health" bill, which is a shame and a mockery in terms of meeting the health needs of the Nation.

which appeared 5 days after S. 1320 was introduced in the Senate—this advertisement appeared in the Worker, this Communist reflecting organ, to which I have referred?

Mr. RYMER. The advertisement was sent out and published in all papers.

Senator DONNELL. Including the Communist paper?

Mr. RYMER. Yes.

Senator DONNELL. Now, you refer to the bill S. 1320 and to the bill S. 545. Have you had occasion to make any study of the success or the contrary of the compulsory health insurance in any other Nation of the world?

Mr. RYMER. No, sir. I have read but I haven't made a study of it.

Senator DONNELL. Did you write the article which was filed here today in your behalf with this committee?

Mr. RYMER. I participated in the drafting of it, sir.

Senator DONNELL. Who else participated in it?

Mr. RYMER. The research staff of our order.

Senator DONNELL. Who is on that research staff?

Mr. RYMER. We have the editor of our magazine.

Senator DONNELL. What is his name?

Mr. RYMER. Mr. Konecky.

Senator DONNELL. And how many persons participated in the preparation of this statement?

Mr. RYMER. About two—three and then certain sources of the order discussed it and read it.

Senator DONNELL. Well, the actual preparation of the statement in the main was by whom?

Mr. RYMER. There are two or three people—Mr. Konecky, Mr. Roberts, myself.

Senator DONNELL. Mr. Konecky, Mr. Roberts, and yourself?

Mr. RYMER. Myself, sir.

Senator DONNELL. Anyone else assist in the preparation?

Mr. RYMER. No, sir.

Senator DONNELL. Just you three gentlemen. What is Mr. Konecky's business?

Mr. RYMER. He is the editor of the magazine of the fraternal publication of the International Workers Order.

Senator DONNELL. He is the editor of that magazine.

Mr. RYMER. Mr. Roberts is on the research staff of the magazine.

Senator DONNELL. And what did you say your job was?

Mr. RYMER. Youth director of the Jewish people fraternal order—a member of the general council.

Senator DONNELL. Have you ever at any time, not merely in the preliminary preparation of this, but at any time, have you made a study of the operation of compulsory health insurance in any of the nations of the world?

Mr. RYMER. I have read material, but I wouldn't say I have made a study.

Senator DONNELL. You could not say you made a study?

Mr. RYMER. No.

Senator DONNELL. Can you tell us any material you ever read on that subject?

Mr. RYMER. Not exactly, sir.

Senator DONNELL. Could you give us the name of any book you ever read?

Mr. RYMER. I don't remember.

Senator DONNELL. You don't recall the name of any book you ever read?

Mr. RYMER. It has been over the years.

Senator DONNELL. You don't recall the names of any books you read on compulsory health insurance in other nations or in any nation?

Mr. RYMER. No, sir.

Senator DONNELL. Mr. Roberts on the research staff, do you know whether or not he has ever gone to any of these foreign countries and made a study there of the operation of compulsory health insurance?

Mr. RYMER. Not that I know of. We based our study mainly on our experience in this country and our experience in our fraternal benefit society in affording to the greatest possible degree we could in the sense of sick benefits, medical protection, and in our judgment and our experience working for social-security measures, particularly unemployment insurance, old-age security, and we thought that on the basis of our experience this one bill meets the needs of the people in a much better way, in fact, the only assured way.

Senator DONNELL. Your particular organization, of course, is a voluntary organization?

Mr. RYMER. That is right.

Senator DONNELL. No compulsion about it; nobody is required to pay any portion of the expenses unless he joins your organization voluntarily?

Mr. RYMER. Yes.

Senator DONNELL. You have never found in this country any instance of compulsory health insurance anywhere?

Mr. RYMER. Not that I know of.

Senator DONNELL. Mr. Roberts is on the research staff. What type of research does he ordinarily carry on?

Mr. RYMER. All legislation literature.

Senator DONNELL. Is he a doctor?

Mr. RYMER. No, sir.

Senator DONNELL. Has he ever studied, as far as you know, the compulsory health insurance in any other nation?

Mr. RYMER. Not that I know of.

Senator DONNELL. Not that you know of. Mr. Konecky, the editor, what is his background? Has he been with the organization since it started in 1930?

Mr. RYMER. For a good many years, 15 or 16.

Senator DONNELL. What was his business before that?

Mr. RYMER. He was editor, I think, of a magazine either of the Odd Fellows or Woodmen of the World.

Senator DONNELL. Do you know whether he has ever gone to any of these foreign countries or other nations and made an investigation of their compulsory health insurance?

Mr. RYMER. I tell you what, sir—a number of medical people who haven't participated in drafting this particular document but have also consulted with us in their statements of this previous bill—well, some of them might have studied or might have even visited other countries.

Senator DONNELL. Which one ever studied?

Mr. RYMER. We have a general medical examiner of our organization.

Senator DONNELL. What is his name?

Mr. RYMER. Dr. Litinsky.

Senator DONNELL. Did he make any investigation of compulsory health insurance insofar as as you know?

Mr. RYMER. Not that I know of. He might have.

Senator DONNELL. Any other doctor that you have in mind that you are referring to ever made any study insofar as you know of compulsory health insurance?

Mr. RYMER. Not that I know of.

Senator DONNELL. Mr. Konecky—did he ever go to any of these countries and make any investigation?

Mr. RYMER. Not that I know of.

Senator DONNELL. Do you know what books he has read on the subject?

Mr. Rymer. No.

Senator Donnell. Do you know whether he has read any?

Mr. Rymer. No.

Senator Donnell. You don't know whether Mr. Roberts ever read any books on the subject?

Mr. Rymer. I don't know.

Senator Donnell. You come in here with this statement here in which, in the first place from this advertisement, I understand you made a very carefully prepared analysis of the difference between this bill and the one of last year. Who prepared this analysis, do you know?

Mr. Rymer. As I told you, it might have been prepared before. It might have been prepared from the material Senator Murray mentioned as having been sent out.

Senator Donnell. It might have been sent from the office of Senator Murray?

Mr. Rymer. It might have and also from our years of experience and analyses of previous bills. We have carefully watched any new bills introduced in this session of Congress.

Senator Donnell. Was there anybody from your organization, the International Workers order, that participated in the preparation of the advertisement appearing in the Sunday Worker of May 25, 1947?

Mr. Rymer. Of this advertisement?

Senator Donnell. Yes?

Mr. Rymer. Why, of course.

Senator Donnell. Who prepared the analysis of differences between S. 1320 and S. 545?

Mr. Rymer. I wouldn't say for certain. My judgment would be it was Mr. Konecky.

Senator Donnell. He is the editor of the paper?

Mr. Rymer. Yes, sir.

Senator Donnell. You think he prepared it?

Mr. Rymer. I think so.

Senator Donnell. Did you see him prepare it?

Mr. Rymer. No, sir.

Senator Donnell. Did you ever hear him say he prepared it?

Mr. Rymer. No, sir; but generally he does; that is why I mentioned it.

Senator Donnell. He prepares what?

Mr. Rymer. Prepares publicity, advertisements.

Senator Donnell. Well, don't you think that he made pretty rapid progress in making his analysis of bills as long as these bills are—S. 1320 and S. 1606—analyzing the difference between them so accurately and carefully?

Mr. Rymer. As I have told you, Mr. Chairman, we have kept pretty closely in touch with this piece of legislation over the years.

Senator Donnell. You don't know actually Mr. Konecky had to do with the preparation of that advertisement?

Mr. Rymer. My general thought would be that he had, because he does all of that.

Senator Donnell. You don't know actually whether he did it in this case or not?

Mr. Rymer. I don't know.

Senator Donnell. That is all.

Senator Ball. Before we get off this issue, I would like to read a paragraph from this. Apparently it was the booklet got out by the national executive committee of the International Workers Order in 1930 urging workers to join the IWO, and it is officially put out by the national executive committee. The paragraph reads as follows:

> The International Workers' Order realizes that the only party that leads the working class in its struggle against capitalism is the Communist Party, which unites the best and proven militant members of the working class and which is bound to become ever stronger until the moment will come when the workers under its leadership will overthrow the capitalist system and establish soviets.
>
> It follows, therefore, that the International Workers Order is part of the battlefront of the working class.

Would you say, Mr. Rymer, if you were reading that pamphlet trying to get you to join an organization, and you would read that paragraph, wouldn't you think that it was part of the Communist Party?

Mr. Rymer. What year was that issued in?

Senator Ball. Issued in 1930 when it was first organized.

Mr. Rymer. Well, I couldn't speak for that publication, sir. I don't know if many of us could.

Senator Ball. I wasn't asking that. If you read that paragraph in a pamphlet attempting to get you to join an organization, wouldn't you sort of think it was either part of the Communist Party or very closely affiliated with it?

Mr. Rymer. I don't know, sir. People have to make up their own minds.

Senator Ball. I see.

Senator Donnell. I appreciate Senator Ball making this contribution but I don't think he read quite all of that, did you, Senator?

Senator Ball. Oh, it goes on.

Senator Donnell. I would like to read the concluding portion of that same paragraph, which says:

> The International Workers Order realizes that the only party that leads the working class in its struggle against capitalism is the Communist Party which unites the best and proven militant members of the working class and which is bound to become ever stronger until the moment will come when the workers under its leadership will overthrow the capitalist system and establish soviets.

Did you read that?

Senator Ball. I did read that.

Senator Donnell. I would like to read just a little bit more, too.

> It follows therefore that the International Workers Order is part of the battle front of the working class. This part, however, is in many respects different from the other parts of the same front. * * *

I also call this to your attention in the following paragraph that Senator Ball referred to:

> We find that the Communist Party is the only party that fights for the workers' interests. We therefore endorse the Communist Party. We appeal to all workers to vote for the Communist Party. We aid the party in its struggles. At the same time, however, we remain a nonparty organization.

That is issued in this document which says on the face, "Issued by the national executive committee, International Workers Order, New York, 1930." Mr. Rymer, when you get this other information, will you also get information for us who paid for this particular publication issued in 1930?

Mr. RYMER. Yes, sir.

Senator DONNELL. Any further questions?

Senator PEPPER. Mr. Rymer, I notice in your statement on page 2 you quote the Rockefeller Foundation in its annual review of 1947, which said:

> One of the troublesome problems of our generation is how we are to make available to the entire population the preventive, diagnostic, and curative services of modern medicine.

Is that a correct quotation from the annual review of the Rockefeller Foundation of 1947?

Mr. RYMER. Yes; from the original.

Senator PEPPER. Insofar as you know, does the Rockefeller Foundation have any connection with the IWO?

Mr. RYMER. Not that I know of, sir.

Senator PEPPER. Is there any close intimate link insofar as you know between the Rockefeller Foundation and the Communist Party?

Mr. RYMER. No, sir; not that I know of.

Senator PEPPER. Has the Rockefeller Foundation made any contributions that you know of to the support of the Communist Party?

Mr. RYMER. Not that I know of.

Senator PEPPER. Has it taken the pledge as members of the Communist Party to support its principles?

Mr. RYMER. I don't know that, sir.

Senator PEPPER. Does the Rockefeller Foundation, as far as you know, follow, for the most part, the Communist line in its publications?

Mr. RYMER. I don't know, sir.

Senator PEPPER. You made a statement from A. J. Altmeyer, chairman of the Social Security Board, in which you quoted him as saying—

> There are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

Is that a correct quotation from A. J. Altmeyer, chairman of the Social Security Board?

Mr. RYMER. Yes; it is.

Senator PEPPER. That is the Mr. Altmeyer who is chairman of the Social Security Board for some time?

Mr. RYMER. Yes, sir.

Senator PEPPER. The same Mr. Altmeyer who has been complimented by the United States Senate in his position as Chairman of the Social Security Board?

Mr. RYMER. So far as I know.

Senator PEPPER. Does Mr. Altmeyer have any connection to your knowledge with the IWO?

Mr. RYMER. No, sir.

Senator PEPPER. Has he any connection with the Communist Party insofar as you know?

Mr. RYMER. Not that I know of, sir.

Senator PEPPER. Was he supported by the Communist Party for the position he now holds as Chairman of the Social Security Board?

Mr. RYMER. I wouldn't know, sir.

Senator PEPPER. Has he kept any clandestine trysts of any character with any member of the Communist Party?

Mr. RYMER. I wouldn't know, sir.

Senator PEPPER. Do you know of any action on his part that would justify that he follows the communistic line in the announcements he makes on this subject?

Mr. RYMER. We judge him purely on the merit of his suggestions and analyses and work on the subject.

Senator PEPPER. I think the Bible says something to the effect that—it was quoted yesterday by a Methodist minister—"Woe unto him that causeth one of these little ones to suffer." Do you believe that to be true?

Mr. RYMER. Yes, I do, sir.

Senator PEPPER. Does anyone who is responsible for causing a child needlessly to suffer or die bear the condemnation of the Bible? You do believe in the Bible?

Mr. RYMER. I do, sir.

Senator PEPPER. You believe that what is in the Bible is right?

Mr. RYMER. Sounds good.

Senator PEPPER. You would not do anything to offend the principles of the Bible?

Mr. RYMER. No, sir.

Senator PEPPER. Now, I realize this may be a technical question, because you are not a physician, I assume, but as far as you have observed, the members of the IWO have relatively the same afflictions as do nonmembers?

Mr. RYMER. They do, as far as I know.

Senator PEPPER. Have you seen any members of the IWO who have appeared to show the effect of germs or contagious disease or illness in any character?

Mr. RYMER. Yes, sir; plenty, including my own personal experience.

Senator PEPPER. Have they been sick in bed and prostrate?

Mr. RYMER. Yes, sir.

Senator PEPPER. Do they seek the services of the regular doctors; do they seek, for the cure of disease, the services of regular doctors and do they seek admission to hospitals and do they allow themselves to be administered to by these practitioners and do they take the medicine that other people generally take which is prescribed for the treatment of disease?

Mr. RYMER. They do, sir.

Senator PEPPER. Do the members of the IWO wish to see their children live and not become victims of disease which is preventable, and do they desire to see their children have medical and hospital care that would prolong their lives and prevent their suffering?

Mr. RYMER. Yes, sir.

Senator PEPPER. Do members of the IWO love their children?

Mr. RYMER. I believe they do, sir.

Senator PEPPER. Do they love their wives?

Mr. RYMER. Yes, sir.

Senator PEPPER. Do they love other members of their families insofar as not wanting them to die because of lack of medical care?

Mr. RYMER. Yes, sir.

Senator PEPPER. Because you believe these humans, who are similarly affected by disease, want a system of medical care better than we now have, do you think, along with a good many other people, that the Murray bill, of which I am one of the authors, I am proud to say, would be a better way of meeting that need? You have come here so to testify?

Mr. RYMER. That is the main reason we came to testify and do not want it confused with any other issue.

Senator PEPPER. You will advise the committee if you discover that the members of the IWO are not subject to the ordinary diseases and germs and put it so in writing?

Mr. RYMER. I promise to do so, sir.

Senator MURRAY. Are you a member of the Communist Party yourself?

Mr. RYMER. I am.

Senator MURRAY. And how long have you been a member of the Communist Party?

Mr. RYMER. A number of years—15 or so.

Senator MURRAY. What is it that attracts people to the Communist doctrine?

Mr. RYMER. Why, I believe the idea they have about promoting social legislation that will benefit the greatest number of people in America, which will be the best thing for our people. Also, if the great riches and resources of our land were owned by the people and the people benefited from these resources as a whole, we feel the country will be better off from that than otherwise. That is the principal idea.

Senator MURRAY. Did you write in here and request to appear as a witness?

Mr. RYMER. Yes, sir.

Senator MURRAY. You weren't solicited as a witness, but you desired to appear?

Mr. RYMER. Yes, sir. We have been associated with campaigns to promote this legislation for years, and when we knew this was up here, obviously we wanted to appear.

Senator MURRAY. You watched the hearings that have been held in the past?

Mr. RYMER. Not only watched, we have participated in these hearings for years past on bills on health and social legislation.

Senator MURRAY. And you received copies of the bill and analyses that were prepared and mailed out?

Mr. RYMER. Yes.

Senator MURRAY. The analyses were mailed out before the bill was filed?

Mr. RYMER. I presume they were, sir.

Senator MURRAY. And you desired then to appear as a witness because of your interest in the subject?

Mr. RYMER. That is right.

Senator MURRAY. You requested to be heard here?

Mr. RYMER. That is right, sir.

Senator PEPPER. Just one other question. Mr. Rymer, if all the people in the United States had access to needed medical care and hospitalization, you wouldn't have had any subject to put in that pamphlet which made such an attractive appeal?

Mr. RYMER. That is right. Not only that, we wouldn't have any cause for arranging sick benefits and medical departments.

Senator PEPPER. Senator Ball has read a statement which purports to be from some committee of the IWO.

Senator DONNELL. The executive committee.

Senator PEPPER. Appealing to the workers. Well, now, if the workers of this country had decent jobs and were getting decent pay and worked under favorable conditions, owned their homes, owned their automobiles, and owned radios and iceboxes, and their children went to school, went to picture shows, and had a chance for summer vacations, and they had access to adequate medical care, and their children had decent public schools, you wouldn't be able to induce them to join up with the IWO under that kind of system?

Mr. RYMER. I don't think so. That is the very system——

Senator PEPPER. It would be pretty hard to get those workers to get out and try to overthrow a society that provided those opportunities?

Mr. RYMER. It wouldn't be necessary.

Senator PEPPER. Isn't it a matter of fact that the best seeds of your appeal fall with most hope and with the greatest chance of fertility upon workers who don't have jobs and who don't have homes and don't have automobiles and don't have health care?

Mr. RYMER. It is because they don't have those things and that activity that we are trying to secure for them.

Senator PEPPER. And when you find them they are more amicable to your trends than they would be if they had them?

Mr. RYMER. Obviously.

Senator PEPPER. It may be an interesting question who are the best friends of the Communist; may it not?

Mr. RYMER. May be at that.

Senator PEPPER. Those who want to make the capitalist give up everything.

Mr. RYMER. Anyone who wants to provide scarcity instead of plenty for the few.

Senator PEPPER. Thank you.

Senator BALL. Mr. Rymer, I take it you do not favor the capitalist system?

Mr. RYMER. No, I don't. It is not giving our people what they are entitled to, sir.

Senator BALL. I believe you stated that you joined the Communist Party and are a member of that party. Do you believe that the Communist system will provide a better living and higher standard of living for people?

Mr. RYMER. I believe so, sir.

Senator BALL. As far as you know, Russia is the only country in the world where the Communist system prevails; is that right?

Mr. RYMER. As far as I know.

Senator BALL. Would you say that the Russian natural resources compare favorably—in fact very favorably—with those of the United States?

Mr. RYMER. I think so, sir.

Senator BALL. How would you say that Russia's standard of living—that the standard of living of the Russian people—compares with that of the people of the United States?

Mr. RYMER. I would say it is lower, to my knowledge.

Senator BALL. And yet you think the Russian system is better than the present system we have in the United States?

Mr. RYMER. I believe that with the know-how and with the natural resources that we have that we could be 10 times ahead of Russia or any other people of the world, for that matter, under socialism, and I believe that we could help the rest of the world that much more than we have been able to up to now.

Senator BALL. You think a dictatorship provides more than the present system, although history indicates to the contrary?

Mr. RYMER. I said if the natural resources of the country were owned by the people of the country, it is then we would certainly all benefit.

Senator BALL. Better than Russia has under a dictatorship?

Mr. RYMER. We are in a different class.

Senator DONNELL. Do you know that the A. J. Altmeyer you quoted from in your statement is the Chairman of the Social Security Board?

Mr. RYMER. As far as I know.

Senator DONNELL. I would like the record to also show that Mr. Altmeyer is the United States delegate to the International Labor Organization on social security. Did you know that fact?

Mr. RYMER. No; I didn't know that.

Senator DONNELL. When did you join the Communist Party; did you say?

Mr. RYMER. About 1932.

Senator DONNELL. About 1932. Are you familiar with the magazine issued by the Communist Party known as The Communist, issued monthly?

Mr. RYMER. I have seen it.

Senator DONNELL. You have seen it. You see copies of it here in my hands now. I would like to call your attention to a portion of this article written by Max Bedacht, entitled, "Ten Years of the Communist Party in the United States." This appears in the issue of September '29, and this particular language to which I call your attention, reads as follows:

> The first of these processes—

He is talking about certain processes.

> concerned the so-called Michigan group which is now leading an existence under the name of the "Proletarian Party." The leaders of this group, the outstanding one of which was John Keracher, proposed to escape the necessity of immediate and intense activities in the class struggle by confining the activities of the party to the class and lecture room. For them the revolutionary struggle of the working class against capitalism was not to be developed out of the daily struggles of the workers against the capitalists for bearable conditions of employment, but was to be the result of educational activities only. Through the class and lecture room the working class was to be acquainted with the theories of Marxism. After a sufficient section of the working class was thus won, it was time for the revolution to start.

Do you know how far along these plans for the revolution have developed to which he has referred there?

Mr. RYMER. I haven't the slightest idea.

Senator DONNELL. You know Max Bedacht has been the general executive of the International Workers Order which you are representing here today?

Mr. RYMER. I do know that.

Senator DONNELL. When I was interrogating you before about who were Communists and had Communist affiliation, it didn't occur to me, as it did to Senator Murray, to ask you whether you were a member of the Communist Party. How did it happen you didn't mention that yourself?

Mr. RYMER. I did not come to testify to that effect. I came to testify on the bill, representing my organization.

Senator DONNELL. You know that I was asking questions designed to show the close identity of the organization which you represent with the Communist Party?

Mr. RYMER. I know that and I don't think that bears any effect and helps to get clarity on the bill on health insurance.

Senator DONNELL. You say that you realized in my questioning that I was trying to bring out the close connection of the Communist Party with the International Workers Order; you know that?

Mr. RYMER. Yes.

Senator DONNELL. All the time you knew you were a Communist and never said a word about it, did you, this morning until asked the specific question?

Mr. RYMER. I was answering questions as you were asking them. I think I have answered all to the best of my ability.

Senator MURRAY. I might say, if he asked you would you have answered him?

Mr. RYMER. I have answered all of his other questions up to now.

Senator DONNELL. You understood that I was trying to develop the close identification throughout the questioning—the close identity between the Communist Party and the IWO for which you appear; you realized that, did you not?

Mr. RYMER. Yes, sir.

Senator MURRAY. I don't see where he could have made that statement without interposing something that was irrelevant to the question. If it had been asked, I am sure he would have answered it. He probably figured with all your cross-examining you would get to it eventually; that you would not close without bringing it out.

Senator DONNELL. I appreciate the Senator's solicitation in bringing that out. I am wondering just what informed him to the fact of asking that question, however.

Senator MURRAY I just assumed that he probably was and I thought it ought to be brought out and placed in the record.

Senator DONNELL. There had been nothing even remotely to my mind at any time that this gentleman had any connection with the Communist Party because of his obvious inference that he knew only by general reputation, rumor, and report what were the connections of these gentlemen with the Communist Party.

Senator MURRAY. I got my idea from your cross-examination. You brought out the fact that the organization was communistic and closely connected with the Communist Party, and I assumed that therefore he must be a member of the party.

Senator DONNELL. I am glad the Senator became convinced of the close identity of the organization because the witness did not intend to develop any such connection.

Senator MURRAY. I assumed you knew what you were talking about and I put two and two together and got four.

Senator DONNELL. I call your attention to an article in the Communist of May 1932. One paragraph is as follows:

> The work of improving the functioning of our party, which certainly must be pushed, and the developing of our mass campaigns must be carried through with the clear perspective of improving our mass organizational work, especially in the factories and among the unemployed, and by utilizing to the maximum

extent the forces, resources, contracts, and apparatus of the mass organizations (TUUL, unemployed councils, IWO.—

That is your organization for which you appear here today?

Mr. Rymer. Sounds like it.

other fraternal bodies, ILD, LSNR, etc., as well as the local unions of the A. F. of L.) as the means of extending the party's organization mass influence.

I also call to your attention, while at this point, that in the edition of the Communist of April 1931, on the concluding pages, appears this statement—this is from an affidavit made by Marie Reiss, business manager, in a statement of the ownership, management, circulation, and so forth, of the publication, the Communist—

> That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Communist Party, U. S. A., 50 East Thirteenth Street. Editor, Max Bedacht, 50 East Thirteenth Street.

Mr. Rymer, Mr. Bedacht at that time was likewise general secretary of the IWO?

Mr. Rymer. I don't know, sir.

(Subsequently Mr. Rymer sent the following communication to the clerk of the committee:)

Rockwell Kent, *General President,* Max Bedacht, *General Secretary,* Peter Shizska, *General Treasurer*

International Workers Order,
New York 11, N. Y., August 14, 1947.

Philip R. Rodgers,
Committee Clerk, United States Senate Committee on Labor and Public Welfare, Washington, D. C.

Dear Mr. Rodgers: In reference to your letter of August 11, I can tell you that documents published under the name of campaign committee or fraternal committee are definitely not documents published by the International Workers Order.

I have confirmed this to the best of my ability upon my return to New York.

Sincerely yours,

Ernest N. Rymer,
International Workers Order.

Senator Donnell. Any further questions, gentlemen?

I am sorry I will have to go but I have another engagement. I am sorry I will not be able to hear your testimony, Dr. Butler, but perhaps I may be back before you are finished.

Dr. Butler. I would have liked to have discussed this with you.

Senator Ball. Will you proceed, Dr. Butler?

STATEMENT OF DR. ALLAN M. BUTLER, APPEARING FOR THE PROGRESSIVE CITIZENS OF AMERICA

Dr. Butler. Senator Ball, and members of the committee, first, I want to apologize for some errors—some mine, some the stenographer's—that crept into the printed statement, and I want to emphasize some things that aren't in the printed statement.

First, I wish to emphasize that S. 545 is in principle just as compulsory as the Wagner-Murray-Dingell bill. Those who make a marked distinction between the compulsory nature of the two bills seem to ignore the fact that payment of the costs of medical care by collection of general taxes is just as compulsory as by specific insurance collections. Of course there is nothing compulsory about obtaining medical care under either act. The difference is that the compulsory payments of S. 545 are hidden, while those of S. 1320 are clearly designated. It would appear that the latter is more conservative, as people well know what they are paying for their medical care, instead of losing sight of the cost and thinking they are getting free medicine.

Senator **Ball**. I don't follow you through, Doctor. How are the costs in S. 545 hidden? There would have to be an appropriation year after year?

Dr. **Butler**. There would have to be an appropriation here and the general public will not get hardly any information about that appropriation, nowhere near as much as they would get in terms of pay-roll deductions.

Senator **Ball**. Sorry to disagree with you. I am a member of that Appropriation Committee and a lot of the public watch the appropriations.

Dr. **Butler**. I am a member of the public. I regret that we don't watch them half closely enough.

Senator **Ball**. They watch us closely and are more aware of what is being appropriated, particularly large amounts, than they are of pay-roll deductions which after a year or two are almost forgotten about.

Senator **Pepper**. You don't forget about taxes.

Dr. **Butler**. You have to pay them, but you pay them in a lump sum, usually in income taxes. I really think as an individual, in paying my income tax I will have an awareness of what proportion of that payment goes to finance medical care. On the other hand, I will have great awareness in terms of any deductions from my payroll. Isn't that fair?

Senator **Ball**. I suppose so. Go on, Dr. Butler.

Senator **Pepper**. Before you go on, I am interested in your observation that there is more of the socialistic approval in S. 545 than in S. 1320. If I understand it correctly, under a Socialist union the individual citizen pays no tax whatever. The Government simply furnishes him all the medical care and hospital care he needs and he pays nothing for it. It seems to me to be more than that. They start off in S. 545, and it says on page 2 under (c) that Congress finds and declares—

> That it is the policy of the United States to aid the States, through consultative services and grants-in-aid * * *

That is the difference—

> * * * to make available medical, hospital, dental, and public-health services to every individual, regardless of race or economic status.

Now, it seems to me that is the declared purpose.

Dr. **Butler**. As stated in the rest of this printed statement, I believe S. 545 is a far more radical or socialistic measure than S. 1320. With the least little what we call aggression, not degression in our economy, you would easily have 80 percent of your people in the United States becoming eligible for medical care under S. 545.

Senator **Pepper**. Starting off with an estimate of 20 percent that would get benefits.

Dr. **Butler**. The AMA itself says that families 5 years ago with $3,000 a year income could not meet the cost of serious illness. That today would be $4,000 and that must be 80 percent of the American public.

Senator Pepper. Suppose, Doctor, this bill were supported by enough men to achieve the declared purpose, how much do you think the appropriation would have to be?

Dr. Butler. In answering that question it should be clearly understood that medical care today is expensive; that the American public today is spending approximately $5,000,000,000 on medical care, outside, perhaps, of what the States are already spending, so that the provision of such medical care as S. 545 might give from general taxes might run into $10,000,000,000 a year.

Senator Pepper. And if it did that, that speaks for itself. Thank you.

Dr. Butler. I asked the committee on economics of the American Academy of Pediatrics when this bill came out what percent of the people in the States of various members of that committee would apply for care under this bill. The answers varied from 30 percent of the people to well over 50 percent of the people, and those were all people who were very conservative-minded and against the Government going into the business of financing medical care.

Senator Murray. In the magazine section of the New York Times last Sunday was an article by some doctor in which he said 97,000,000 people in the country were in need of medical care.

Dr. Butler. That was a very reasonable article.

Senator Pepper. Doctor, I wanted to ask one other thing. You gave some estimate of information that you obtained of the probable number of people that might apply for this kind of aid. Might we suggest in connection with that subject the fact we have, I believe, 16,000,000 citizens in this country who have enjoyed the fullest of State medicine during the time they have been in the Army and Navy. They got complete medical care free. All they had to do was go ask for it and it was received. This comes nearer to being like the type to be given under the insurance system, of one paying into a common fund on a sliding scale for medical care.

Dr. Butler. I think, Senator, it is a less conservative way to introduce Government-supported medical care than is the insurance principle which is incorporated in S. 1320.

Senator Murray. If we had desired to put over social medicine in this country we couldn't have proceeded any better than proceeding in the manner S. 545 has. We could have opened the door for socialized medicine in the country and would have had an opportunity to have it expanded from time to time and would have had a complete system of socialized medicine.

Dr. Butler. I agree with you.

Senator Murray. We would have been accused of being communistic and socialistic and atempting to put over socialized medicine in this country. If we really had desired to do that, we would have proceeded to do it the way Senator Taft and his associates have proceeded.

Senator Ball. Very interesting but pretty far-fetched in my opinion because I have seen plenty of exactly the same kind of procedure that was proposed in S. 545 on the local and State level. You are doing it now in your county and city hospitals and this simply says to step up that type of service a little to take care of some people that haven't come under it so far. That is all it is doing. If that is socialized medicine, then I don't understand the term.

Whereas, if you have a compulsory Federal insurance system, that is, a Federal insurance system that is going to control the medical profession, it is going to dictate the standards of the doctors that practice and all the rest of this is simply filling in the weak spots in the present system and leaving it as it is.

Dr. Butler. It is filling in the weak spots in the present system without taking any precautions to have the standards set up as this type of Government expenditure is expended.

Senator Ball. S. 1320 wants to have the Federal Government step in and set the standard for the whole medical profession, all over the country.

Senator Pepper. Before we get away from the subject, let's take this suggestion that the chairman made. This bill contemplates the appropriation of $200,000,000 of Federal money. I think we are agreed that this is to be $200,000,000 a year by the Federal Government, plus amounts to be put up by the States which will adequately meet the medical needs of the country.

If we have it for more than 1 year—2 years—and there are still many people not getting the medical care that they need and not able to get it, what is to prevent them from raising it to three hundred million or four hundred million or five hundred million and on toward a figure that will satisfy the need sufficiently? Whereas, the person who is making the demand is the small taxpayer. His own taxes are probably substantially increased and the Federal appropriation increased so that he has a taste of the good medical service provided out of the Federal Treasury, and then becoming aware that he is still not getting his needs met, and not having the ability to bear the increased taxes, isn't it human that he, as a citizen, is apt to support the candidate and support the party who promises more?

Whereas, if every time more adequate services are increased, that pay-roll tax which he has to pay is increased, will he not have some personal interest in the amount of the increase? Under the Murray bill it is contemplated the tax be 1½ percent upon the employee and 1½ percent upon the employer. We know that the employer passes that on to the public and it will have to pay for the increased cost. It seems logically that the doctor is absolutely correct in the observations that he made.

Senator Ball. Let me pursue that a little. Mathematically, medical service will cost the country upward of $15,000,000,000 a year?

Dr. Butler. No.

Senator Ball. You said that the country is now paying about $5,000,000,000 a year in addition to whatever the States and the local communities are paying, which is a sizable sum, and you stated S. 545, if it really did everything that should be done, would cost $10,000,000,000 a year.

Dr. Butler. You shouldn't add those two sums.

Senator Ball. You mean the Federal will take over the whole thing?

Dr. Butler. Under S. 545, with a little depression, your legislation could be providing free medical care out of the general taxation fund to some 80 percent of the people and that, of course, means cutting down on the amount those people were paying in terms of those private contributions.

Senator BALL. I don't follow you. I don't see it. Under a depression, no matter how serious, we never have over 10 or 15 million unemployed. The rest of the people are working. Doctors' fees tend to go down along with everything else. Salaries go down. Your ability to buy medical service stays about the same, fortunately. I can't follow you through. I think it might go up some in a depression, but we won't have to have such levels as that.

Dr. BUTLER. I think you forgot, the American Medical Association says people with incomes of $3,000 a year cannot finance serious illnesses.

Senator BALL. Serious illnesses?

Dr. BUTLER. They all come under this bill.

Senator BALL. I know a Member of the United States Senate who had great difficulty in financing a prolonged illness, but there is no way you can set up a system that will take care of those situations. You are taking care of the average situation and the average need. I admit in a serious illness even wealthy people run into financial difficulty.

Dr. BUTLER. That is what puts up the cost of our medical care, and under this bill people who encounter such serious illnesses that they cannot afford to pay in whole or in part, become eligible for medical care. I think I am correct in saying you will have people whose family income is $3,000 a year falling under eligibility under this bill.

Senator BALL. You might have one or two—yes. But you are not going to have a great many.

Dr. BUTLER. You are going to have a great many.

Senator BALL. If that were the case, Doctor, systems like the Blue Cross system would have gone bankrupt.

Dr. BUTLER. The Blue Cross system does not handle medical insurance.

Senator BALL. It handles hospital.

Dr. BUTLER. That is a very different business.

Senator BALL. Same principle.

Dr. BUTLER. There are 26,000,000 people in the United States insured under Blue Cross quite successfully.

Senator BALL. I know it.

Dr. BUTLER. There are about 3,000,000 people insured under the extension of those State services that provide medical care and the coverage is very, very limited. So there is a great difference between Blue Cross hospital insurance and medical insurance. Medical insurance on a State-wide system in these United States has yet to prove it can work on a volunteer basis. The Blue Cross works very well on a volunteer basis. I would say there are 3,000,000 people covered.

Senator BALL. And how many years have they been?

Dr. BUTLER. Almost all the societies, the companies backed by the medical societies that are operating medical insurance on a State-wide basis in the United States, are just skimming by and they are threatened with bankruptcy every minute and have no idea whether they are going to be successful next year or not.

Senator BALL. Lots of businesses have trouble meeting pay rolls. But, of course, no insurance system will take care of exceptional cases. You have got to strike an average. It is like the hospital insurance. It doesn't pay the whole hospital bill if you are in for months and months but it does take care of the first couple or 3 weeks, which is what most families run into. The medical insurance would be pretty much the same.

Dr. BUTLER. A medical system similar to the Blue Cross covers very little in the period of medical illness.

The other things which I think you all appreciate—the big hospitals—charity hospitals of the United States today are admitting to their charity wards—not for free hospital beds as some of these people pay for their hospital board, but for free medical care people who have family incomes of $25,000 a year, and they are accepted as charity patients who cannot pay their professional medical bills. That is done all over the United States today. That gives you an idea of how many people fall under this.

Senator BALL. You mean that the county and State authorities do that knowingly?

Dr. BUTLER. They do it knowingly.

Senator BALL. $25,000 a year?

Dr. BUTLER. It is common practice throughout the United States today.

Senator BALL. Well, I am sorry, but I know in my State if they find any person with a $25,000-a-year income who is in a charity bed in a county hospital, they go after him to collect the bill.

Dr. BUTLER. You have misunderstood. I didn't say Government hospitals. I didn't say city or county hospitals. I said the big private charity hospitals are receiving them.

Senator BALL. Which hospitals do you mean, for example?

Dr. BUTLER. The Presbyterian Hospital of New York City, the Johns Hopkins Hospital in Baltimore.

Senator BALL. That isn't just a charity hospital. It has some charity beds.

Dr. BUTLER. They are classified as private charity hospitals and as such are exempt from taxation.

Senator MURRAY. Nonprofit; they are exempt from some of the laws because of that.

Dr. BUTLER. They render charity service.

Senator BALL. Most of their beds are paid for. Most of their services are paid for.

Dr. BUTLER. No, not most; and the main thing to get across is——

Senator BALL. Certainly different from the ones in my State.

Dr. BUTLER. They pay some cost of the hospital as under their hospitalization, but they don't pay any doctor for the professional services he renders in those hospitals—not a single penny.

Senator BALL. I think the hospital is slightly nuts——

Dr. BUTLER. That is the way it is.

Senator BALL. If they let people with $25,000 a year incomes get by with a free ride.

Dr. BUTLER. You will find, Senator, on investigating the case, just as AMA has said, those people are actually unable to meet the cost of their medical care.

Senator BALL. I would like to see a few of the specific cases.

Dr. BUTLER. You just go and consult the administrator of any of the hospitals in the big cities in the United States and you will find that to be a practice.

Senator BALL. It certainly doesn't make any sense. I have had quite an experience with quite a few hospitals and I never met any of them who operated that way.

Dr. BUTLER. I assure you my statement is correct.

Senator BALL. I am wondering how the United States could stand that matter, counting the Veterans' Administration and all the Federal hospitals. I suspect they are spending over $35,000,000,000 a year now—well over it.

Dr. BUTLER. That may be so.

Senator BALL. According to your statement, that would probably run up somewhere around 15 or 20 billion. Can you take that much out of this economic system for medical service?

Dr. BUTLER. My statement was based, I think, on the statement of Senator Pepper, which presupposed that S. 545 would be covering the great majority of the people in the United States.

Senator BALL. You said 80 percent.

Dr. BUTLER. If it did, my statement was that the total cost in providing medical care to those 80 percent would be $10,000,000,000. That doesn't mean you can add on to the figures that are now being paid because they will be transferred from the payments now being made under whatever is going on today to what will be going on.

Senator BALL. I am afraid you are talking about figures that are impossible. I don't think you have enough doctors to pay out $10,000,000,000 today.

Dr. BUTLER. We are paying $10,000,000,000 today for our medical care.

Senator BALL. Are you taking in hospitals and the whole business?

Dr. BUTLER. I am taking in the whole business—Government medicine, private medicine.

Senator BALL. I agree; but if you are covering hospitals and the whole works, so does S. 545. Are you talking about medical cases?

Dr. BUTLER. Both; I am talking about S. 545.

Senator BALL. What do you estimate, if we had the ultimate medical care for everybody in this country, how much, including hospitals, and what would it take out of the national income?

Dr. BUTLER. I think it is silly to consider the very ultimate care.

Senator BALL. It seems to me that is what you are talking about. You are getting way beyond any amount we are spending today. Obviously, S. 545 is designed to fill some gaps in the present services. With two or three hundred million dollars, with Federal systems to be matched by State and local systems, that is an entirely different thing from the start and ought to provide complete medical care for everybody in the United States.

Dr. BUTLER. I agree with you, but for 5 years.

Senator BALL. Particularly on a level which we never reached—even the well-to-do families in this country.

Dr. BUTLER. I think you are mistaken. The first 5 years S. 545 limits its payment to $200,000,000 a year. After that the lid is off, and I think Senator Pepper is right in suggesting when the lid is off, the public having tasted what they think is free medicine, will demand more of it and should there be a little recession in our economy, you will get the 80 percent of the public claiming eligibility under this bill and then you might get the cost of the medical care under this bill reaching $10,000,000,000.

Senator BALL. You are presupposing, of course, that all State legislatures and Congress have no regard whatever for the economic welfare of the country and that they will respond to the pressure on a purely political basis and hike the cost with no regard whatever to what it will do to the economy. I think you run up exactly against the same program every time you embark on any social security legislation. You are going to have pressure, as under the GI bill of rights, social security payments and all the rest, which will keep increasing. If we do it continuously, we will wreck the economy, no doubt about it.

Dr. BUTLER. Except as far as you can improve the Nation's economy by bettering the Nation's health.

Senator PEPPER. Congress might decide, as the doctor suggested, that is the best way to improve the economy.

Senator MURRAY. Right there—in this article in the New York Times these figures appear:

> The stated annual cost of sickness and accidents in loss of earnings due to sickness is $8,000,000,000. The total hidden cost of sickness and disability wage loss to workers cost to industry totaled more than $15,000,000,000 in 1943.

Those figures you think are reasonable, Doctor?

Dr. BUTLER. I do. I don't think the figures we have been mentioning are not reasonable. May I continue?

Senator BALL. Yes, proceed.

Dr. BUTLER. Second, S. 545 does not favor voluntary insurance and is not conservative in that sense. If people can get the Government to pay such costs of serious illness as they cannot afford, how many will voluntarily pay a private concern to do so, especially when no private concern will give as complete coverage?

Hence, all this propaganda by the American Medical Association that S. 545 is conservative, voluntary, evolutionary, and the American way, while S. 1320 is social medicine, dictatorship, and communism it literally just so much tommyrot.

I'm sure such nonsense does not affect the opinion of this committee whose members know the bills. But it should be clearly understood that it unfortunately does prejudice doctors, the public, and perhaps Congressmen who haven't read them.

Now, to consider some specific points on S. 545.

Senator BALL. Are you opposed to the feature that provides that the administration of the program should be predominantly in the hands of doctors of medicine?

Dr. BUTLER. I am opposed to barring the possibility that the administrator be an individual other than a practicing physician because in so doing you may bar the administrator who has the best qualifications for that position. I am opposed to having the advisory council predominantly practicing physicians, as I think those advisory councils should be individuals who have medical administration, medical public health service, and know the problems of hospitals and the consumer public. And to have them predominantly members of the medical profession practicing medicine I think is wrong.

Senator BALL. They can be public health doctors. They can be doctors who have had a lot of experience in public health work.

Dr. BUTLER. I am afraid they set up the possibility they won't be.

Senator BALL. That doesn't make very good sense to me. It seems to me if I were going to improve a system of roads, I would want the administration to be by a man who is an engineer who knows something about the roadbuilding business. I am a little leery of having people outside of the medical profession.

Dr. Butler. I think I agree if we limit that to the operational level of the medical service, not to the administrative and policy levels. For instance, our Secretary of the Navy is not an admiral, and we wouldn't want him to be.

Senator Ball. The Surgeon General of the Army is a doctor.

Dr. Butler. That is an operational level, not the policy administration.

Senator Ball. He makes a lot of policies.

Dr. Butler. He does have representing him at a higher level someone who isn't an Army or Navy man.

Senator Pepper. Doctor, do you happen to recall—I don't know, I am asking for information—the head of the Rockefeller Foundation; is he a doctor—administratively?

Dr. Butler. Of the Rockefeller Foundation—no, he is not.

Senator Pepper. That carries on a great research and medical program.

Dr. Butler. Yes.

Senator Pepper. But the administrative head is not a doctor.

Dr. Butler. When you get to the fellow who actually does the research, there you have the professional doctor. The Secretary of Labor, Senator Ball, is perhaps not always an individual who is a professional laborer; and we would not want him so.

Senator Ball. He has an entirely different position from the administrator of a public-health program.

Dr. Butler. I don't know how different.

Senator Ball. I am sorry. He is purely an administrative, political official. I mean, he has no highly technical job to do.

Dr. Butler. Neither, we hope, will the person who is the administrator—the Federal administrator of the national health program under S. 545 have any technical job to do. That would be a great mistake. He should be an administrator who deals with policies, not the technical performance.

Senator Ball. It seems to me a layman is not the right person to determine policies on public health.

Dr. Butler. You have an advisory council that will have on it the individuals who know the professional end.

Senator Ball. I have never seen an advisory council yet that had very much power or authority to get very much done. The administrator is the key man. As a matter of fact, he appoints his own council and his council usually, if they follow the precedents in other organizations, will go along with the administrator.

Dr. Butler. I take it you subscribe or do you not subscribe to the administration set up under S. 140?

Senator Ball. My name is on the bill.

Dr. Butler. That is what I thought.

Senator Ball. I don't say the bill is perfect. I am sorry—not S. 140. I am talking about S. 545.

Dr. Butler. I was talking about S. 140, which is the reorganization bill. I shall continue.

Senator Ball. Yes, proceed.

Dr. Butler. Had the findings and recommendations of this bill concerning need of reorganization and coordination of the health and medical functions of the Federal Government been declared over a year ago, they might have deserved some consideration. However, President Truman's reorganization plan, which was put into effect a year ago accomplished in our opinion a more satisfactory organization and coordination of health and medical functions within the Federal Security Administration than is accomplished by the present bill, S. 545. It would be unfortunate if political considerations led to scrapping agencies already organized and coordinated and thus ignored the possibility of constructively building on what we now have. If further emphasis and coordination of health and medical functions are desired, reorganization bill S. 140 appears to accomplish this far better than does S. 545.

Worthy of particular comment are the findings that there are inadequacies in the distribution of public health, medical and dental services with the result that some persons are unable to secure adequate health and medical services and the declaration that it is the responsibility of the Federal Government to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status. Senator Pepper has commented on that. Apparently the American Medical Association endorses this and thus for perhaps the first time publicly admits that adequate medical care is not available to everyone who seeks it and that steps should be taken to make health and medical services available to all. Let us hope that from now on the official representative of the AMA and the Journal of the American Medical Association will stop making claims to the contrary.

Comparison of the administrative provisions of the Wagner-Murray-Dingell bill of 1946 with those of S. 545 is interesting because the AMA particularly through its propaganda agency, the National Physicians Committee, has damned the former and endorsed the latter. The administrator of each is appointed by the President; each administrator appoints the members of his advisory council; each appoints the Directors of the constituent units. In the Wagner-Murray-Dingell bill, the advisory council can exert influence over the acts of the Administrator by filing opinions with the Administrator's annual report to Congress and the President. In S. 545 no such continuing authoritative position is given the council. It can, however (see sec. 712), over-ride the Administrator in his disapproval of State plans and of certification of grants. The major differences that account for the AMA's apparent inconsistency appear to be:

1. S. 545 prescribes that the Administrator must have practiced medicine and that members of advisory councils shall be predominantly doctors. Thus, public health trained administrators or lay representatives of the consumer public are in effect barred from administrative positions.

2. The specifications of section 712 pertaining to the personnel of State medical and hospital care advisory councils also favor their domination by the forces of organized medicine.

3. Under the Wagner-Murray-Dingell bill the Administrator with the approval of the council may protect standards and quality of service rendered under State plans, whereas under S. 545 he or any

Federal employee has no "right to exercise any supervision or control over the administration personnel, maintenance or operation of the health services with respect to which any (Federal) funds have been or may be expended under this title." Thus, the Taft bill, S. 545, places authority at the State levels and favors domination of the National Health Agency and State Agencies by the AMA and State agencies by the AMA and State medical societies.

The National Health Insurance and Public Health Act of 1947 by establishing administrative authority in a board rather than an individual has sought to avoid the criticism of promoting dictatorship. This Board will be composed of the Surgeon General of the Public Health Service, the Commissioner for Social Security, and 3 full-time members appointed by the President with the advice and consent of the Senate. At least one of these three must be a doctor of medicine licensed to practice in one of the States. Their salaries will be $12,000 per annum and their terms of office 6 years, with appointments staggered at the beginning so that one member retires every 2 years. One of the three appointed members will be designated as Chairman of the Board by the President. Yet the National Physicians Committee raises the cry that under the act doctors will become servants "taking orders from a departmental bureaucrat." They also misrepresent fact by stating that only one of the members of the board shall be a doctor, conveniently omitting the "at least one" from the statement.

Incidentally, such misrepresentation is typical of the propaganda that the AMA's National Physicians Committee has been spreading throughout the country for several years.

It would seem to be a sound principle of American democracy that the Federal agencies dispensing public moneys be held responsible to the people for the quality of what is purchased. Such responsibility cannot be fixed without delegation of some authority. Study of the Wagner-Murray-Dingell bill of 1946 or the National Insurance Health Act of 1947 reveals the delegation of carefully restricted authority to an extent consistent with desirable administrative responsibility.

Dr. E. A. Park, emeritus professor of pediatrics, Johns Hopkins Medical School, in speaking at the New York Academy of Medicine, said the Taft bill—

> Suggests undertaking to provide care for medically indigent persons through payment of insurance premiums with tax moneys to all types of nonprofit voluntary plans. This would appear to be a policy based on fallacious reasoning since it would involve inappropriate use of public money and would be unsound governmental procedure. It is a long-established principle that tax moneys should be expended by public agencies which are accountable to public officials representing the taxpayers. This is a basic principle in the organization of our Government and hence a vital consideration against the Taft bill proposal aside from the fact, as I have pointed out above, that voluntary plans do not generally assume responsibility for meeting more than the vary partial medical needs of their members.
>
> It seems astonishing that Senator Taft and his associates should have allowed to be introduced into his bill a suggestion flaunting this time-honored principle. S. 545 is obviously written to appeal particularly to those to whom Federal control is anathema. The Taft bill vests essentially all the authority in the individual States and reduces the Federal control to impotence. If the Wagner-Murray-Dingell bill was carefully thought through and made to face issues squarely, the Taft bill is poorly thought out and avoids controversial issues, except for its central thesis of States' rights, by passing them on to be fought out in the individual States. It contains provisions fraught with peril. For example, the bill provides that no plan or modification shall be disapproved because the (Federal)

Director disapproves of the methods proposed. This would probably be interpreted as prohibiting the establishment of Federal standards which a State would have to meet in order to have its program approved. Virtually all of the existing health legislation requires the establishment and maintenance of personnel standards on a merit basis. Such Federal legislation has been a most important factor in taking politics out of Health Department appointments. Such a merit system clause was in the original Taft bill introduced last year, but its omission is conspicuous in the present bill. The removal of this would open the State programs to political appointments. Proposals in the bill would allow the State to purchase services through any nonprofit voluntary insurance program without any standards whatsoever. This would permit State and Federal funds to be used to subsidize poorly operated voluntary insurance programs.

If the bill were passed as it stands, there could be as many different systems of medical care as there are States. Some of these in the more progressive States would probably be very good, in some other States exceedingly poor, and all would be laid open to the possibility of political intrigue and inefficiency.

If it is wrong to give all the power in health legislation to the Federal Government, it is worse to place it all in the States and to have no national integration or coordination. In determining Federal and State relationships there must be a happy medium in which the Federal Government establishes the general scheme and fixes minimum standards and the States have freedom to develop their own systems within the Federal structure.

Another major difference between the Wagner-Murray-Dingell bill or National Insurance Health Act of 1947 and S. 545 is that the former sets up an insurance program financed by specific premiums paid by the employed or self-supporting people of the country, whereas the latter provides charity medicine financed from general tax funds. Nowhere in the bill is there a definition of eligibility for this charity medicine. As the AMA itself has admitted that families with incomes equivalent today to $4,000 per year cannot meet the expenses of serious illness, the vast majority of individuals may be eligible as "medically needy." If costs of illness are to be deducted from earnings in determining the net income which will define eligibility under this bill "to provide general health, hospital, and medical services for families and individuals with low income," individuals will be continually changing in eligibilty status because of health or illness as well as earnings.

Remembering also that an individual's eligibility for 0, 10, 20, 50, 75, or 100 percent of costs of medical services will have to be decided at each application for aid, the complicity of determining eligibility, the opportunity for political influence, the annoyance and distastefulness to the public are obvious—indeed so obvious that it is difficult to understand how the American Medical Association could have ignored the fact that this bill will require per unit of service rendered not only a bureaucracy and administrative expense but also opportunities for "political medicine" far greater than would ever result under such a National Health Insurance program as proposed in the Wagner-Murray-Dingell bill of 1946 or the National Health Insurance Act of 1947.

As mentioned by Dr. Park, the problem of devising means to determine eligibility is avoided completely in S. 545. The uneconomical and distasteful bureaucracy required by this impractical "means test" is unnecessary under the National Health Insurance Act. Under this act anyone making an insurance payment is eligible as an insured person. Anyone not making such a payment is eligible for medical service as a needy person. And yet the National Physicians Committee and the AMA objects to the bureaucracy of an insurance bill and ignores that which would be required by S. 545.

Moreover, if 50 percent of the people, as is likely, should be eligible to have a part of their medical care paid for from general tax funds, as S. 545 proposes, then that program is certainly more socialistic than a National Health Insurance Act. The AMA may advocate ill-controlled socialized medicine financed from general tax funds, but the Progressive Citizens of America prefer conservative insurance programs.

It is difficult to think of a way to introduce Federal support of medical care that could carry a greater threat to the quality of medical care than does S. 545. Insofar as this bill is conceived in terms of charity medicine for those of low income, it favors meager remuneration for services rendered. Insofar as no provision is made for maintaining standards, for encouraging research and education such as are included in the National Health Insurance Act, no provision is made for protecting quality. How better could legislation be devised that would undermine American medicine? And yet it is endorsed by those who should be responsible leaders and representatives of both the medical profession and the consumer public.

In considering this bill, S. 545, certain questions appear particularly pertinent:

1. Is S. 545 a conscientiously conceived and thoughtfully executed act for the development of national health, not only in the sense of extending health and medical services but also of improving standards and advancing knowledge? Our answer is "No."

2. Is S. 545 introduced by those who oppose Federal financing of medical care so as to forestall legislation which would provide a better basis for the development of national health? Is it considered as the least that will satisfy public demand and hence is a limiting rather than a constructive legislation? Our answer is "Yes."

3. Is this national act of 1947 introduced merely as a political move by those who wish to avoid the charge of having opposed national health legislation but who also do not intend to have any such legislation passed? We hazard the answer "Yes."

Consideration of S. 545 has led the Progressive Citizens of America to the following conclusions:

1. It is ill-conceived legislation which is inimical to the health of the Nation and to the medical profession.

2. It is a political move and a means of forestalling effective legislation rather than a constructive health act.

3. It might easily introduce ill-controlled socialized medicine on a charity basis supported from general tax funds.

4. It threatens the quality of American medicine because:

(*a*) There are no standards enforceable at the Federal level;

(b) Except for meager support of dental research, there are no provisions for the support and encouragement of medical education and research such as are provided in the national health insurance act;

(c) The fact that the medical services are conceived of as charity medicine for families and individuals of low income favors a low scale of professional remuneration and thus may undermine the adequate remuneration of the entire profession.

5. Finally, enactment of this legislation might retard the improvement of medical care of the American people for an unpredictable period.

Therefore, the Progressive Citizens of America strongly oppose S. 545 and urges passage of the Murray-Wagner-Dingell National Health Insurance Act as far more soundly conceived and conservative means of improving the medical care and health of the American people.

Senator BALL. I am wondering how soon PCA is going to move over and say it is reactionary.

Dr. BUTLER. I think one of the most conservative things we do in a democracy is to assure the expression of minority opinions in the discussion of current issues.

Senator BALL. I agree with you.

Dr. BUTLER. One of the things that has bothered me about the American Medical Association in relation to the consideration of the social and economic problems of medicine is that the American Medical Association has never permitted in its journals it controls a discussion of those problems. It merely presents its points of view and damns other points of view without presenting them.

Senator BALL. Isn't that rather customary in a house organ, so to speak? I never saw the CIO defending the Taft-Hartley bill.

Dr. BUTLER. It may be the custom, but for a group of doctors who are extraordinarily well educated—sections of the American public who are financially, for the great part, removed from the struggles that might lead to prejudice—I think it is a rather serious thing that the great journals controlled by that organization do not practice the fundamentals of democracy regarding free discussion of minority opinion.

Senator PEPPER. In somewhat the same vein as you have just made your last statement, doesn't it take a good long while before the opinion of the rank and file among the profession can ever come to expressions as an official policy of the organization, the AMA?

Dr. BUTLER. Yes, Senator; and that is again, I think, one of the things that worries you about the competency of the medical profession today in dealing with the problems that face them regarding the provision of better health to the American people. For years those doctors have had given to them through the journals controlled by the medical association, which are the journals they read for professional reasons, only one aspect of these problems. They know no other. They are shockingly prejudiced, therefore. A few weeks ago I happened to be invited to speak before a community medical society of Maine at their annual meeting. They asked me to discuss these two bills. I asked this audience—some 115 physicians around Portland, Maine—how many had read the bill. One individual had read it. Yet they almost to a man had formed opinions concerning them. Those opinions had come from things written in the AMA journals and from the little things put out by the National Physicians Committee.

Have you, Senator Ball, ever happened to glance at the type of propaganda that is put out by the National Physicians Committee as regarding the Wagner-Murray-Dingell bill and your bill?

Senator BALL. I may have, but I don't recall. I have been a little busy with other work.

Dr. BUTLER. Well, here is one that came on my desk 10 days ago, and it just hooks medical legislation with communism, fascism, revolutions, in a most extraordinary manner. That is what the doctors get when they begin thinking about such legislation as you and Senator Taft have introduced, and they are just so prejudiced about it, it is very difficult to make them really consider the thing rationally. So that most doctors' opinion concerning this type of legislation today, unfortunately, is worth practically nothing.

Senator PEPPER. One other question I would like to ask you. Has there been a change in the announced attitude of the high organ of the AMA in the last few years, sort of an about-face in their interest in finding some better methods or finding adequate medical care for the people?

Dr. BUTLER. I think they have improved a little bit. Up to a little while ago they denounced everything that proposed anything, and then they saw the demand was growing so strong they had to turn to some outlet, to some substitute to meet this demand, and they began to counsel one another to the effect that "if we don't get any substitute they are going to pass these bills up here—this national health act," and they started to look around for voluntary insurance plans, and the medical societies started to form some sort of cooperatives of their own, and they began to take the position that they were not against what they would have called socialized medicine a little bit ago.

Senator PEPPER. Is there any truth in their general opinions I read about?

Dr. BUTLER. I think your impressions are pretty direct, as most of your impressions are——

Senator PEPPER. Thank you for that. I think that is going to reflect a little bit on the other statements you made.

Dr. BUTLER. I think it is more than that, Senator Pepper. I think the AMA has been forced by a good deal of opinion in the State medical societies to do something about the social and economic problems of medicine. I think there has been some change of influx, people at the top, not enough to allow the top fellows to have changed their attitude, but it is much better. But the encouraging thing is that in the State societies there is a large section of practicing doctors who really want these questions dealt with. I, for instance, am a member of the committee on medical economics of the Massachusetts Medical Society and am on the council of the Massachusetts Medical Society. I think I hold those positions because they feel I have sincerely studied the social and economic problems in medicine. I am a minor member, to be sure, but it shows they are interested in minority opinion and respect it.

There is hardly a week goes by that young men don't come into my office and say, "We have come in to see how we can avoid being forced into the current type of private medical practice. We don't want to have to practice medicine that way. How can we set up something where we can render better medical care to our patients?" and that influence is increasing throughout medical societies. That is where I think the AMA is changing its position.

Senator PEPPER. Doctor, I have always had a feeling that there is something to be said, and you gave expression to the extent of security for a doctor; I will be frank to say that in my practice of law when I got interested in a case I was scarcely conscious of financial opportunities because I was fascinated by the lure of a particularly interesting point. Some of my partners had to keep reminding me that we had to take in some money, too, in the office to pay for our business and to live. And I know, generally speaking, men go into the practice of medicine not primarily to make money. They are attracted by the opportunity of service in their particular field. I still believe that a man who is worthy of being called a doctor is primarily concerned with administering his profession. He is not a money maker; he is not an economist. Many professional men are notoriously poor economists. Many doctors—as fine men as the Lord ever made—will be in debt because they don't collect their bills.

Now, it seems to me that, as you say, a given doctor, if he had a system by which he had a certain number of patients, assuming the capitation system—take a certain number of patients and get a certain amount of money for looking at them—he could devote his intellectual efforts and his physical strength to looking after those patients if he had a regularly assured income. If we could just get the bugs out of this national health act.

Senator DONNELL. Which act is that?

Senator PEPPER. I mean the National Health Insurance Act. It seems to me if we can do this, it will afford security to physicians that the mass of physicians do not enjoy.

Dr. BUTLER. It is very funny, Senator Pepper; I mentioned in my evidence before this committee last year that the private physician's struggle for maintaining his independence—he has already lost it. He is just the servant of his private patients. He can't leave his office for a minute without having his telephone number where he is going recorded. He can't go away for a week, as he is afraid he will lose his patients. I agree with you that the practicing physician will get more independence than he has ever had before, and he will be able to render better medical service than he ever rendered before under the system of private practice.

Senator PEPPER. Thank you.

Senator BALL. The majority of them do not feel that way.

Dr. BUTLER. The young men do.

Senator BALL. They prefer their independence.

Dr. BUTLER. Not the young men.

Senator BALL. Young men sometimes have ideas that they change as they grow older.

Senator PEPPER. That was a gathering of young men in 1873, and they did a pretty good job. They had foolish dreams that they made come true.

Senator BALL. Thank you, Doctor. We will recess now until 2 o'clock.

(Whereupon, at 11:40 a. m., a recess was taken until 2 p. m.)

AFTERNOON SESSION

The subcommittee reconvened at 2 p. m., pursuant to recess.

Senator DONNELL. The committee will be in order.

Next is Mr. Leslie S. Perry, administrative assistant, National Association for the Advancement of Colored People, Washington, D. C.

Dr. COBB. Mr. Chairman, I am Dr. Cobb, speaking for Mr. Perry.

STATEMENT OF DR. W. MONTAGUE COBB, REPRESENTING THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, WASHINGTON, D. C.

Senator DONNELL. Will you please state your name, your address, and the organization for which you appear?

Dr. COBB. W. Montague Cobb, representing the National Association for the Advancement of Colored People, Washington, D. C. I am professor of anatomy in the School of Medicine of Howard University and president of the Medico-Chirurgical Society of the District of Columbia.

At this time it is my privilege to represent the National Association for the Advancement of Colored People, as a member of its national medical committee. The national association is well known as the largest and most representative organization of colored Americans. It has approximately 600,000 members, with 1,509 branches, youth councils, and college chapters in 43 States.

On April 16, 1946, it was my honor to appear under the same auspices and in the same capacity to testify in support of the national health bill, S. 1606, of the Seventy-ninth Congress, before the United States Senate Committee on Education and Labor. That testimony appears on pages 500 through 508 of part I of the published hearings on that bill and adequately defines the position of the national association on national health legislation now before the Congress.

On June 28, 1947, the Thirty-eighth Annual Conference of the NAACP, meeting in Washington, D. C., and attended by more than 800 delegates from all parts of the country, adopted unanimously the following resolution:

> The NAACP has maintained an active interest in national health legislation. We endorse and support the principles embodied in the national health bill, S. 1320. We are opposed to the Taft bill, S. 545, of the Eightieth Congress, because of inadequate coverage, inadequate financial provisions, impractical administrative procedures, and the probability of this bill permitting the continuation of discrimination, since control of its administration will be in the hands of the States.
>
> The national association shall work toward the elimination of the segregated principle as it is now entrenched in all arrangements for medical care as applied to Negroes. We do not recognize a distinction between medical care for Negroes and for other segments of the American people, and consider that this care for Negroes will be adequately covered only when adequate medical care for the entire country is provided.

Our previous testimony, cited above, renders unnecesary here a detailed discussion of Negro health needs. It will suffice to point out that although the average American life expectation has been increased from 35.5 years in 1789 to about 64 years today, the life expectancy of colored Americans has shown a constant lag of about 10 years behind that of white. This indicates that while the Negro has shared in the benefits of the advances in medicine, public health, and general welfare responsible for the increase in average longevity, he has never done so as fully or as rapidly as the rest of the population, and he brings up the rear of backward regions.

The national association is most deeply concerned that advances in any field making for the improvement of health be fully shared by all citizens. Hence it has a vital interest in the improvement of economic status, public health measures, sanitation, housing, and provisions for medical facilities and care.

In S. 545, the principal interest of the national association is in those sections dealing with medical services. Under this bill, the only persons for whom such services would be provided are "individuals with low income." What would constitute low income is not defined.

"Low income" apparently would be separately determined by the several States, or regionally within a State. In localities where racial wage differentials are traditionally notorious, the presumption has to be that "low income" would be defined at a lower figure for colored than for white citizens. In such areas, the bill could mean no progress, because where some citizens are presumed to require less income than others for their total necessities, their health needs also would be presumed less and they would get less of any benefits provided.

The definition of "low income" would be contingent also upon funds available. In periods of legislative economy, these could be expected to be so restricted that practically only persons on relief rolls would be eligible.

S. 545 does not state clearly the way in which medical care would be furnished. It is merely prescribed that—

> Such program may, at the option of the State, provide medical care in one or more of the following ways: in institutions, in the home, or in physicians offices.

Moreover—

> Such program may include and take account of services rendered or to be rendered by governmental subdivisions of the State, and by private organizations operating not for profit, and may provide for the payment to such institutions by the State or subdivision for care to such families and individuals.

Under this blanket option, there is nothing to prevent a State from discriminating in the treatment of the same diseased condition for different groups of citizens. For example, the modern treatment of pneumonia involved the use of laboratory typing, oxygen, the sulfa drugs, and antibiotics, as well as older procedures.

These therapeutic aids require hospitalization. Under the option in the bill, a State could give a white pneumonia patient full hospital treatment, but provide only for home, if any, treatment for a colored patient similarly affected, without violating the law. The traditional explanation would be that no hospital facilities were available for colored patients.

The language of the bill does not refer to the matter of free choice of physician, so much cited by opponents of the national health-insurance and public health bill, S. 1320. Apparently, the "low income" patient could be made to secure his medical services from whom and under whatever plan a State would see fit to dictate.

The "low income" concept is particularly defective when high-cost medical services are considered. The American Medical Association's own survey in 1939 conceded that persons with incomes of less than $3,000 a year could not meet the costs of serious illness without assistance. A comparable estimate today would probably be around $5,000, which would mean that between 80 and 90 percent of the population would have to be classified as needy. With respect to expensive medical services, 90 to 95 percent of our population would have to be so characterized. There is obviously no such intention on the part of a bill which would provide only $200,000,000 a year for medical services.

Again, with a "low income" classification, a huge, costly, and unnecessary administrative organization would be required for the sole purpose of determining who qualified as "needy" in the varying standards of particular localities. This could mean only endless confusion and expenditure without serving any medical end whatever.

Finally, the "low income" classification would turn back the clock in establishing on a national basis a "poor" or "charity" caste, with its associated stigma, a category which progressive social action has been gradually eliminating over at least the past two decades.

In respect to the single feature of "low income" classification, S. 545 is nebulous, inadequate, discriminatory, wasteful, and atavistic. If enacted into law, no one could predict how long its evil effects would halt real progress.

Senator DONNELL. Doctor, there is one word here that I do not understand. What is that word "atavistic"?

Dr. COBB. It means a recurrence in some individual of some ancestral characteristic that has long dropped out of sight. That is, a man born with his face covered with hair is said to be atavistic.

Senator DONNELL. Thank you. I am not familiar with the term.

Dr. COBB. Yes, Mr. Chairman.

The administrative organization prescribed by S. 545 is so drawn that State and county medical societies and the American Medical Association could influence the operation of the plan to a controlling degree. The national association finds this arrangement particularly objectionable.

In the 17 southern States and the District of Columbia, colored physicians are excluded from membership in county and State medical societies which are the affiliates of the American Medical Association. Membership in the AMA is contingent upon membership in the local and State organizations.

In a historic controversy of 1870 centering about the exclusion of Negro physicians by the Medical Society of the District of Columbia Association sustained this exclusion by refusing to recognize other than a single local medical body and has never deviated from this policy, despite constant representations and demonstrations over the years, of the wrong and practical detriment thus perpetrated upon Negro physicians.

An extension of the exclusion of colored physicials from medical societies is their exclusion from hospital staffs both public and private. This obtains with a few exceptions not only in the South but in the great urban centers of the North and West. Obviously, this markedly handicaps the Negro physician both as to his training and the service he is able to render.

More than civic groups, affiliates of the American Medical Association have been resistant to efforts to obtain relaxation of restrictions against Negro physicians and segregated practices against Negro patients.

Moreover, in contrast to the national representative organization of nurses, which has taken steps to recognize organizations of colored nurses, the American Medical Association has taken no measures at a national level which would encourage an enlightened point of view in State and county affiliates.

The National Association could not have confidence in the equitable administration of a program which could be controlled by an organization with the record of the AMA in respect to the Negro.

The antidiscrimination clauses in the bill would be meaningless because control would be in the hands of the States without provisions for enforcement, Federal or otherwise.

In such particulars as plan of organization, benefits, methods of payment for services, provision for maitenance and enforcement of quality in services, financing, and controls, S. 545 also appears inadequate.

In this statement the chief concern of the national association has been with the provisions for medical services. In respect to these, S. 545 does practically little else than preserve the existing systems of paying for such services, and make a new demand upon the Federal Treasury for a totally inadequate lump sum to provide medical care for the indigent.

The failure of existing provisions for payment for medical services to meet the needs of the American people has largely given rise to the present public demand for comprehensive legislation for medical care on a national basis. The NAACP reaffirms its endorsement of the principles represented by S. 1320 and opposes the limited and partisan approach represented by S. 545.

Senator DONNELL. Senator Murray, you have just entered the room?

Senator MURRAY. Yes.

Senator DONNELL. Are there any questions you would like to ask of Dr. Cobb?

Senator MURRAY. No questions.

Senator DONNELL. Doctor, may I inquire, did you collaborate with anyone else in the preparation of this statement, or did you prepare it entirely yourself?

Dr. COBB. The writing is my own. The discussion of the contents was in conference with officers of the association.

Senator DONNELL. Of the association. I see. I do not think there are any further questions to ask you, Doctor. Thank you very much for your attendance.

Dr. COBB. Thank you, Mr. Chairman.

Senator DONNELL. Is Mr. Leo J. Linder present?

Mr. SILBERSTEIN. Mr. Chairman, I am not Mr. Linder. He is unable to be here, but I shall attempt to speak in his place.

Senator DONNELL. Please state your name, your address, and the organization for which you appear.

STATEMENT OF ROBERT J. SILBERSTEIN, NATIONAL EXECUTIVE SECRETARY OF THE NATIONAL LAWYERS GUILD, WASHINGTON, D. C.

Mr. SILBERSTEIN. Mr. Chairman, my name is Robert J. Silberstein, national executive secretary of the National Lawyers Guild. My address is 902 Twentieth Street NW. I have been a member of the bar of the State of New York since 1932, in active practice since then except for 40 months' service in the Army of the United States.

The National Lawyers Guild is an organization of more than 3,000 lawyers.

Senator DONNELL. May I interrupt you to ask about yourself, Mr. Silberstein?

First, what is your connection with the National Lawyers Guild?

Mr. SILBERSTEIN. I stated, Mr. Chairman, I am national executive secretary, a full-time officer.

Senator DONNELL. A full-time officer. That is to say you are employed by the National Lawyers Guild on a salary. Is that right?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. And you devote all of your time to the work of that organization?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Are you going to tell us something of what the National Lawyers Guild is?

Mr. SILBERSTEIN. I was about to do that, Senator.

Senator DONNELL. All right, proceed.

Mr. SILBERSTEIN. The National Lawyers Guild is a bar association having in excess of 3,000 members, drawn from most States of the United States, with local chapter organizations in some 12 of the States.

It has all of the functions of any other national bar association and has from the time of this organization, exercised a genuine interest in the field of social legislation.

You will recall that Mr. Linder, the chairman of our national committee on social legislation, testified at great length before your committee on two occasions last year and demonstrated an exceptional understanding of the provisions of the bill.

Senator DONNELL. Yes. What was the occasion for the organization of the National Lawyers Guild, Mr. Silberstein?

Mr. SILBERSTEIN. The National Lawyers Guild was organized early in 1937.

At that time the organization which proposed to speak for the whole bar of the country was the American Bar Association. It was felt by those who were active in the organization of the guild that there was another point of view held by many thousands of lawyers in the country which was quite different from that of the American Bar Association. For instance, at that time, the American Bar Association was active in opposition to the child-labor amendment, and took other positions on matters of social legislation which did not represent the point of view of many lawyers. It was thought that an organization should be created that would give voice to the liberal and progressive lawyers of America. It was also felt that the American Bar Association gave inadequate attention to matters worthy of attention, and that a new organization could serve the members of the bar and the people if it would undertake to work in that field.

Finally it was the feeling of thousands of lawyers that the American Bar Association had failed to take a stand in the defense of the constitutional rights of the people, and the National Lawyers Guild has from the time of its organization been most active in the defense of the constitutional rights of the people.

Senator DONNELL. You think the American Bar Association had failed to show proper interest in the preservation of the constitutional rights of the people of the United States?

Mr. SILBERSTEIN. I am not certain, Mr. Chairman, but I am quite sure prior to the organization of the National Lawyers Guild the American Bar Association did not have a committee on constitutional rights. It does now have a committee known as the committee on the Bill of Rights, but so far as I know, it has not been active in cases which it is generally felt did affect the constitutional rights of the American people.

Senator DONNELL. Among the presidents of the American Bar Association has been Charles Evans Hughes, who at one time was Chief Justice of the United States and a member of the permanent Court of International Justice. That is correct, is it not?

Mr. SILBERSTEIN. Yes. I do not want it understood as casting any reflection on the American Bar Association. I am just explaining why those who came into the guild felt there should be another organization. I am sure that it had another point of view. It is important that this point of view should have a means of expressing itself.

Senator DONNELL. Among the past presidents of the American Bar Association was Hon. John W. Davis, Democratic candidate for President of the United States.

Mr. SILBERSTEIN. I have said nothing in contradiction.

Senator DONNELL. No; but I am asking you if it is not a fact that among a number of distinguished members of the American Bar Association was there not John W. Davis, Democratic candidate for President and Mr. Hughes was also a candidate for President on the Republican platform. They were candidates for President from each political party and have occupied positions of highest esteem and confidence in our national life. That is correct, is it not?

Mr. SILBERSTEIN. Yes; it certainly is.

Senator DONNELL. The American Bar Association consists of approximately 135,000 lawyers?

Mr. SILBERSTEIN. Oh, no.

Senator DONNELL. I am wrong on that. It consists of something like 35,000. I was confusing for a moment the figures of the American Medical Association. The American Bar Association has something over 35,000?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. And your organization has about 3,000?

Mr. SILBERSTEIN. May I say something with respect to that?

Senator DONNELL. Yes.

Mr. SILBERSTEIN. Distinction must be made between membership in the American Bar Association and membership in the Lawyers Guild.

If you are a lawyer I think you will agree with me that perhaps 80 or 90 percent of the members of the American Bar Association join it for one or two reasons, either because they want its monthly publication or because they feel it gives them more prestige.

Senator DONNELL. I do not agree with that. I am a lawyer and I am a member of the American Bar Association.

However, you are entitled to your opinion on that, Mr. Silberstein, and I do not mean in the slightest to cut you off from expressing it.

You may proceed, but I want it perfectly clear I do not agree with your conclusions.

Mr. SILBERSTEIN. The point is, people who join the guild do so because they agree with its policies and activities. It is my impression that is not true in the American Bar Association or in the local bar associations.

Senator DONNELL. Just how widely have you investigated the American Bar Association to arrive at that opinion?

Mr. SILBERSTEIN. I confess I have never investigated it. I have spoken to many lawyers. I was a member of the American Bar Association myself until some time after the formation of the Lawyers

Guild and I am quite sure that it is true that at least 50 percent of the Lawyers Guild are still members of the American Bar Association.

Senator DONNELL. The point I was getting at, you made a very pointed statement about the purposes of the American Bar Association in joining it.

I want to know what investigation you have made to arrive at that conclusion.

Mr. SILBERSTEIN. I have made none. It is my personal opinion.

Senator DONNELL. Your personal opinion.

Senator MURRAY. The general impression in the country is the American Bar Association is an ultraconservative organization.

Mr. SILBERSTEIN. I believe that is true, Senator.

Senator MURRAY. They have taken a position against liberal legislation for many many years. Is that not true?

Mr. SILBERSTEIN. That is true, Senator.

Senator MURRAY. Notwithstanding the fact that the officers and representatives of the American Bar Association are fine gentlemen, but they have a different viewpoint——

Mr. SILBERSTEIN. That is right.

Senator MURRAY. From other lawyers that have joined this other organization?

Mr. SILBERSTEIN. Yes, sir.

Senator MURRAY. That is true, is it not?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. You spoke of the general impression of lawyers all over the country. Again I ask you what investigation you have made as to the alleged ultraconservative tendency.

Mr. SILBERSTEIN. As stated before, I have conducted no investigation. I have spoken to different lawyers around the country. I also cannot believe the majority of the 180,000 lawyers around the country would take a position in opposition to every piece of social legislation, because it is contrary——

Senator DONNELL. Mr. Silberstein——

Mr. SILBERSTEIN. It is purely my personal opinion. I do not claim I made any investigation. It has no more value than I said so.

Senator DONNELL. What I want to get is your basis for the statement as to the impression around the country with respect to the American Bar Association.

You say you have talked to many lawyers. How many lawyers have you talked to on that particular subject?

Mr. SILBERSTEIN. Not more than a hundred.

Senator DONNELL. Nor more than a hundred?

Mr. SILBERSTEIN. No.

Senator DONNELL. Have you talked to 25?

Mr. SILBERSTEIN. Approximately 100.

Senator DONNELL. How widely scattered were these hundred lawyers you talked to over the country?

Mr. SILBERSTEIN. I have been in close contact with lawyers in Boston, in Detroit, in Cleveland, in Chicago, in Washington, in New York, in Baltimore, and in Philadelphia.

Senator DONNELL. And you have talked to lawyers in all those various cities in regard to their view as to whether or not the American Bar Association is an ultraconservative organization. Is that right?

Mr. SILBERSTEIN. No, sir.

Senator DONNELL. Have you talked to them as to the reasons why the majority of the members of the American Bar Association have become members of it?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. With those 100 people?

Mr. SILBERSTEIN. Yes, Senator; I have discussed with them how it is that the American Bar Association has so many members and we have relatively few. The question was, Does this indicate the position of the American Bar Association represents that of the majority of the lawyers? And the feeling among the people has generally been "No," that most people who join join because they want the publication. I want the publication and want to read it every month, and do, because there are many ideas and valuable things in it, and many other people join because they want to be able to say when they write something down about what they belong to, they belong to the American Bar Association. I joined it for that reason. I wanted the publication, and I thought if I wanted to list my name somewhere it would be nice to list my name as belonging to the American Bar Association.

I also belong to one of the most exclusive bar associations in the country.

Senator DONNELL. Which one?

Mr. SILBERSTEIN. The Association of the Bar of New York. I have never attended but one meeting, and that was on the question of whether women should be admitted. I believed they should, and so I attended.

I belong to it because they have the finest law library I know of right near my office.

Senator DONNELL. Your offices are near Forty-second Street?

Mr. SILBERSTEIN. 285 Madison Avenue, and Fortieth Street.

Senator DONNELL. Your organization was in fact organized as a protest against what you considered to be ultraconservatism of the American Bar Association. Is that right?

Mr. SILBERSTEIN. I think not.

Senator DONNELL. You think not. It was organized, as you have indicated, to enable persons to express a different viewpoint from the point of view expressed by the American Bar Association?

Mr. SILBERSTEIN. And I said also to provide the means for a member who took an active part in the defense of the constitutional rights of the people, and with the idea it is a very important element that there should be an organization that takes a more active part in trying to help the lawyer in trying to help make legal services available to many, many millions not otherwise available to them.

Senator DONNELL. You say there are many millions of our people who do not have the services of lawyers available to them?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Have you made any investigation of that subject?

Mr. SILBERSTEIN. Yes; we have made some investigation to the extent we have read the report of the American Society of Law Schools which conducted a survey in Connecticut, and the director of the legal reference panel of the Bar Association of the city of New York made the statement there were millions of people in New York and vicinity who did not have the benefit of legal service.

Senator DONNELL. You have free legal aid in New York and have had for many years. Is that not right?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. It is open to any resident of the city of New York?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Do you know the gentleman, a professor at Duke University, who has been the head of the National Legal Aid Society of this country?

Mr. SILBERSTEIN. I do not think I do. I think you misunderstand me.

Senator DONNELL. Perhaps I do.

Mr. SILBERSTEIN. The Legal Aid Society takes care of people who are indigent. If they have any means the Legal Aid Society will not care for them. The people I am talking about are the people above that, who have some means. I am talking about workers, small shopkeepers, white-collar workers, and a lot of professional people, too. They do not get legal services for many reasons.

This is something I am very much interested in and will go into, if you wish, at great length.

The Bar Association of New York has set up a panel to bring together the people who do not know whether they have a legal problem or not, and they have sought by means of consultation to find out, and secondly there are a lot of people who know they have a legal problem and do not know a lawyer or anybody they have confidence in, so the Association of the Bar of New York has set up this panel.

Senator DONNELL. So the Association of the Bar of the city of New York has voluntarily taken action to provide this?

Mr. SILBERSTEIN. It has.

Senator DONNELL. All right.

Mr. SILBERSTEIN. And we are endeavoring to render that service.

Senator DONNELL. Is Mr. Kenny the president of your organization?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Did you see the interview he gave set out in PM a year or two ago in which in substance he said the American Bar Association is a decadent organization?

Mr. SILBERSTEIN. I saw that statement only in the published hearings. You referred to that statement when Mr. Linder was here?

Senator DONNELL. Yes; I did.

Mr. SILBERSTEIN. I would not make that statement.

Senator DONNELL. Yes.

Mr. SILBERSTEIN. I would not even make the statement Mr. Linder made.

I think I made the statement that would represent the point of view of the organization. We do not criticize the American Bar Association. In many fields it is doing excellent work. It is just a different point of view.

Senator DONNELL. I am very much interested in your reference to the committee of the American Bar Association to provide for the defense of the constitutional liberties of the people of this country.

I know of no one among the officers, the president, and I might mention names, a former law partner of mine, I have never seen anybody connected with the American Bar Association who was unmindful of the constitutional rights of the citizen.

Mr. SILBERSTEIN. I do not either. All I have said is that the American Bar Association as an organization has not taken an active part as we do. We intervene as friends of the court in cases we feel involve a violation of constitutional rights.

If we have a trial down in South Carolina in Greenville, of an unprecedented nature in the United States, a confessed lyncher, our vice president will go down and observe that trial.

Senator DONNELL. Your organization has somewhat the same attitude as the American Civil Liberties Union?

Mr. SILBERSTEIN. That is right, and we feel that a bar association has a very real responsibility to do that kind of thing.

The American Bar Association has come to recognize that to a degree. They have organized a committee on the Bill of Rights. I must say I have not heard of them taking part in any cases that raised the question of constitutional rights.

Recently there was a decision by the Supreme Court of the United States that just about wiped out the provisions of the Constitution as to unlawful search and seizure. We filed a brief amicus in support of an application for rehearing.

The moment I heard about this case I wrote to the chairman of the Bill of Rights Committee of the American Bar Association and urged that they give consideration to intervention in this case, to express their views one way or the other. I never received a reply. We do that often in very important cases, and we will write to the American Bar Association.

We have expressed the view on other legislation and made reports.

Senator DONNELL. You regard the American Bar Association as worthy of consideration?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. You are familiar with the fact the American Bar Association has clearly expressed itself on this legislation?

Mr. SILBERSTEIN. I read many expressions of their views on S. 1606.

Senator DONNELL. You remember when Judge Logan Martin, of Birmingham, testified?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. About the same date Mr. Linder testified?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Will you proceed with your testimony?

Did you provide copies of your statement?

Mr. SILBERSTEIN. There were 75 copies furnished.

I shall not read it in full. Rather I shall greatly abbreviate it from what you have there, Mr. Chairman.

Senator DONNELL. But you desire the whole statement to go into the record?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Very well; it will be done. Proceed.

Mr. SILBERSTEIN. President Truman in his message to Congress on May 19, 1947, said that our country has thus far failed to provide protection against the basic risk of sickness. He stated that the national welfare and security urgently required the immediate adoption by the Congress of a five-point, long-range health program. In the words of the President:

> The heart of that program is national health insurance. Until it is a part of our national fabric we shall be wasting our most precious national resource and shall be perpetuating unnecessary misery and human suffering.

We agree with that statement of the President.

The prime feature of S. 1320 is the creation of a Federal system of medical, dental, and hospital care, available virtually to every employed and self-employed person in the United States, and to all of his or her dependents. It proposes to vest in virtually every American the fixed legal right to medical, hospital, and dental care, wholly without regard to whether he has or does not have "insufficient income to pay the whole cost of such services." Thus, the Wagner-Pepper bill proposed, on insurance principles, to give Americans the right to the care they need.

S. 545, on the other hand, would provide Federal aid to such States as provided medical and dental care to "families and individuals with low income." The bill would, indeed, provide Federal aid to States which adopted acceptable State programs for health inspection services and dental inspection services, but actual medical and dental care would only be provided by the States to the children of the families having "insufficient income to pay for the whole cost of such services." Thus, S. 545 is, in essence, concerned with paupers and with people who, if not paupers, are unable to pay the full cost of medical and dental care. The care to be provided under S. 545 is available only upon some demonstration of insufficient income. It is given as a matter of charity in accordance with local administrative determination of need. No American under S. 545 has any right to medical care; at the most, if his State qualified for Federal aid, he might have a right to medical relief if he could demonstrate inability to pay for the full cost of the medical care needed.

Senator Taft has declared that his bill would—

> probably extend medical care to from 20 to 25 percent of the population.

Yet S. 545 states in section 2 (c)—

> That it is the policy of the United States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual, regardless of race or economic status.

S. 545 is obviously not designed to implement that policy.

Presumably this is because Senator Taft assumes that only 20 to 25 percent of the poulation is in the condition of having insufficient resources to meet the full cost of medical care. Yet a report of the American Medical Association indicates that in 1940, families with incomes under $3,000 a year generally could not meet all the costs of medical care. In 1941, 85 percent of the American families had incomes of less than $3,000 a year. While incomes have increased since 1941, living costs have increased even more. It may therefore be assumed that 85 percent of the American families are today unable to take care of all of their needs for health services.

S. 545 thus ignores the fact that a substantial majority of the American people, and not a mere 20 to 25 percent, cannot meet the costs of adequate medical, dental, and hospital care.

In principle, it is clear that the Nation as a whole is vitally concerned that all Americans should receive medical care when they need it. The experience of selective service showed this in most dramatic form.

In the fields of old-age insurance and unemployment insurance, our country has advanced from the notions of Elizabethan poorhouse charity to a conception of creating a system of vested rights to insurance benefits during periods of unemployment and in old age. S. 545 still clings to the outmoded approach of the Elizabethan poor laws. It is based upon a conception which should be emphatically rejected.

There in no assurance whatever that any medical, dental, or health care will be provided to anyone under the provisions of S. 545.

S. 545 appropriates money which is to be given to States provided the States submit State plans. There is no compulsion upon any State to submit such a plan. A State may decline to submit a plan or it may submit a plan which is not approved. In either event, the Americans resident in such State would be wholly without any benefit under S. 545.

Nor is there any assurance that even the limited proposals of S. 545 will be put into effect immediately or in the ner future. For S. 545 contemplates State plans—

> designed and calculated by the end of a five-year period—

to provide medical care—

> at a cost within the probable financial resources of the State with Federal aid.

The States are required to put up an amount equal to the amount of Federal aid. But the States must be in need of aid or at least able to increase their present expenditures.

Thus, S. 545 really provides no certain assurance that its proposals with respect to health care will be made available to anyone.

The limitations upon the health care to be provided under S. 545:

The State programs contemplated by S. 545 must be "designed and calculated to provide within 5 years" services for families and individuals in the State having "insufficient income to pay the whole cost of such services." It is up to the State to determine what constitutes "insufficient income." The State plan must provide for the collection of proper charges of less than the total cost of the services from persons unable to pay in whole, but able to pay in part therefor. Thus, the State would have to set up administrative machinery for investigation to determine precisely what the income and resources of the individual are, and machinery for making sure that the services are paid for to the extent that the individual can pay for them.

Insofar as dental care for children is concerned, this is to be provided only where the children's families have "insufficient income to pay for the whole cost of such services" and where the families are able to pay in part, the plan requires the "collection of proper charges" to the extent of the ability to pay.

This, therefore, is a proposal which will have the effect of dividing our school children on the basis of the economic status of their parents.

So far as medical care is concerned, the State plan need only provide for services at an institution. A State plan may, at the State's option, provide for medical care at the patient's home or physician's office, but this is not required. I understand that even the New York Academy of Medicine objected to this provision. What is here proposed is a system of relief medicine. S. 545 formulates no standards for what it describes as "insufficient income to pay the whole cost" of the medical services involved. Each State would decide for itself, or it would leave it to its counties, towns, or cities to decide what constitutes insufficient income. Each State would decide for itself what would constitute proper charges to be imposed upon persons "unable to pay in whole or able to pay in part" for medical services received. Each State would decide for itself what kind of medical care and what kind of dental care should be provided for.

The "periodic physical examinations" for school children are not related to any effort to correct conditions found. There is no provision whatever in the bill for laboratory services, for drugs, for X-ray, for physiotherapy, for home nursing services. There is no provision in S. 545 to indicate the method of payment for professional services. There are neither maxima nor minima provided, nor are any formulas or standards indicated.

From the standpoint of administration, S. 545 is designed to place the control of administration in the hands of practicing physicians. Its provisions would debar Public Health Service administrators who are not medical or dental practitioners. Whereas in their 1946 proposal the proponents of S. 545 were content to leave administration primarily in the hands of the Surgeon General, the present bill indicates an effort to divorce the Public Health Service from any participation in the administration of a program of medical and dental care, and sharply to differentiate and separate the administration of preventive from therapeutic services.

The inadequacy of S. 545 from the standpoint of its financial provisions is apparent.

S. 545 would spend $200,000,000 annually on a program of medical services. If the States were to spend $1 for every Federal dollar granted, this would mean an expenditure of $400,000,000 annually on the program provided by this bill. In the last few years medical care expenditures by the American people approximated $5,000,000,000 annually. This bill thus proposes an expenditure of 8 percent of current expenditures for medical care. Such a sum could not be expected to provide for any but the lowest-income bracket of those in need.

The appropriations for dental care are deemed by the Physician's Forum to be—

> so trivial, relative to the need, as to be hardly a gesture in recognition of the problem. Starting out with an annual amount of grants of $8,000,000, it builds up to $20,000,000, sums which, when matched, would provide much less than 10 percent of present expenditures for dental care. Present expenditures are, of course, far smaller than required to meet our dental needs, so that the surface of the total problem will hardly be scratched when the maximum appropriation is reached.

In comparison with the limited and restricted proposals of S. 545, S. 1320 proposes not only substantially complete coverage but comprehensive services emphasizing preventive medicine, diagnosis, and early treatment of disease, with elaborate provision for protecting professional people rendering services.

We approve the commendable proposal for financing further research in the fields of dental science and cancer. The proposals for appropriations to finance a dental research institute and cancer research are all warmly approved. Unfortunately these commendable proposals are tied to a program which is not a satisfactory alternative to S. 1320.

In conclusion I would state that S. 545 should be rejected. It does not meet the urgent need for medical care of the people of the United

States. Indeed, it ignores the need for medical care on the part of the majority of the American people.

While unquestionably those who are impoverished should be provided with medical care, this care should be provided as part of a system of medical care available to all Americans.

The overwhelming majority of Americans who are self-supporting are still unable to pay the unexpected cost of a catastrophic or prolonged illness, and it is not in the national interest to deny them care, or to subject them to the degradation of a means test before they can receive the medical care which they need.

Furthermore, the restriction of governmental aid for medical care to Federal grants to the States means that we must rely upon State by State action, and that unless each State acts, its citizens receive no benefit. The disease and ill health of Americans everywhere is a matter of national concern, and it is thus in the national interest that a national system should assure Americans everywhere the medical care they need.

S. 1320 meets the national need by creating a national system administered locally. It provides the medical care which is needed without inquiry as to the means of the recipient and upon the same basis of right as is applicable to unemployment-insurance benefits and old-age insurance benefits.

S. 1320, accordingly, should be enacted, and S. 545 should be rejected.

Senator DONNELL. Mr. Silberstein, the written statement which you have filed here was dated May 24, 1947. Was it prepared at that time or is that an error in date at the bottom?

Mr. SILBERSTEIN. My best recollection is that on that date there was a meeting of the executive committee of the National Lawyers Guild. In advance of that date a subcommittee of the national committee headed by Mr. Linder and Mr. Wainger had prepared an analysis of S. 545 and had sent it out to all members of the national committee, which comprises some 60 lawyers around the country, and they had been polled on their opinion as to the basic principles involved in S. 545 as against S. 1320.

Senator DONNELL. You say prior to the meeting of May 24, 1947, they polled the members of the National Lawyers Guild?

Mr. SILBERSTEIN. All of the members of the national committee on social legislation.

Senator DONNELL. That is the national committee on social legislation of the Lawyers Guild?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. What was that a report on?

Mr. SILBERSTEIN. The provisions of S. 545 and S. 1606, indicating also the changes in S. 1320 from S. 1606. The result of that poll indicated substantial unanimity in opposing S. 545 and in support of S. 1320. This report was presented to the national executive committee of the guild at a meeting which took place on May 24, and at that time was presented the report. This was not in this form. Argument was presented and views expressed by members in answer to the poll, and that is embodied by the chairman of the committee, Mr. Linder, in this report.

Senator DONNELL. In taking that poll, was there sent to each member of the committee a copy of S. 545 and S. 1320?

Mr. SILBERSTEIN. No, sir.

Senator DONNELL. What was done so that they might know the contents?

Mr. SILBERSTEIN. The provisions were outlined of each bill.

Senator DONNELL. S. 545 and S. 1320?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Who outlined them?

Mr. SILBERSTEIN. Mr. Linder and Mr. Wainger.

Senator DONNELL. Was there any comment made by those gentlemen, or were they verbatim quotations from the two bills, S. 545 and S. 1320?

Mr. SILBERSTEIN. I believe that they individually did express their views.

Senator DONNELL. That is, Messrs. Linder and Wainger expressed their views?

Mr. SILBERSTEIN. That is right, pointing out that the National Lawyers' Guild at its annual convention for a number of years, including its last annual convention in Cleveland in July 1946, approved the principles in S. 1606.

Senator DONNELL. That is, Messrs. Linder and Wainger pointed out to members of this national committee to whom this information was sent the fact the National Lawyers' Guild had previously gone on record approving the principles of S. 1606?

Mr. SILBERSTEIN. Yes; and if you like, I can read the actual resolution adopted.

Senator DONNELL. You may do that later; but how long before this meeting of May 24, 1947, was it this inquiry was addressed by Messrs. Linder and Wainger to the members of this national committee who were polled?

Mr. SILBERSTEIN. I would say around 2 weeks before. However, they do not determine the policy of the organization.

Senator DONNELL. Approximately 2 weeks before the meeting of May 24, 1947, this synopsis of the two bills was sent out showing the differences between S. 545 and S. 1320?

Mr. SILBERSTEIN. I should point out I do not believe S. 1320 had been printed with that number, but we did have available the provisions.

Senator DONNELL. As a matter of fact, the bill was not filed until 4 days before?

Mr. SILBERSTEIN. But I had received advance proofs.

Senator DONNELL. Also you gentlemen had received an advance proof of what was contemplated to be filed?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Do you remember from whom you received it?

Mr. SILBERSTEIN. I believe we got it from the committee on the Nation's health.

Senator DONNELL. Is that the organization with which Dr. Boas and Dr. Frothingham are associates?

Mr. SILBERSTEIN. I know——

Senator DONNELL. Do you know whether Michael M. Davis was chairman of the committee?

Mr. SILBERSTEIN. I know Michael M. Davis was connected with it.

Senator DONNELL. So you think you got the advance proof of what the bill was to be from the Committee on National Health?

Mr. SILBERSTEIN. I do not know. I think so.

Senator DONNELL. You know among some of the others was Dr. Boas?

Mr. SILBERSTEIN. I do not.

Senator DONNELL. And Dr. Butler, who testified about it, and Dr. John P. Peters.

Mr. SILBERSTEIN. The only people I have ever met was Mr. Davis, and I believe the secretary of the committee, Miss Stein.

Senator DONNELL. Miss Peggy Stein?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Who sits here this afternoon?

Mr. SILBERSTEIN. I believe so.

Senator DONNELL. Did you receive any advance copy of what this was from Miss Stein?

Mr. SILBERSTEIN. I do not know. It came in the mail. I think it went directly to Mr. Linder. I do not know anything about that, but in any case I know the advanced version was substantially the same.

Senator MURRAY. I would like to ask the witness if he would make an inquiry to discover whether or not I mailed copies of this bill direct to the Guild.

Mr. SILBERSTEIN. That may be quite correct.

Senator MURRAY. I tried to send it to as many as I could.

Mr. SILBERSTEIN. That may well be; it came from your office.

Senator DONNELL. Will you also ascertain whether or not a request was made by anyone connected with your organization to the Committee on the Nation's Health for a copy of advance proof of the bill which was later denominated as S. 1320 and furnish that to the clerk, Mr. Rodgers?

Mr. SILBERSTEIN. I will if it is possible.

Senator DONNELL. I will be obliged if it is possible.

Mr. SILBERSTEIN. All right.

(Subsequently, Mr. Silberstein addressed the clerk as follows:)

NATIONAL LAWYERS GUILD,
Washington 6, D. C., October 28, 1947.

Mr. PHILIP R. RODGERS,
Clerk of the Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

DEAR MR. RODGERS: I have your letter of October 27, with which you enclosed a galley proof of part of my testimony on the health bills. In connection with the request of Senator Donnell that I ascertain whether or not a request was made by anyone connected with my organization to the committee for the nation's health for a copy of advance proof of the bill which was later denominated as S. 1320, I give you the following information:

An examination of our files discloses that on May 3 Senator Murray wrote to Mr. Martin Popper, our national vice president at this office, advising that the national health insurance bill would be introduced shortly. He enclosed a summary of the main provisions of the bill, indicating the changes which had been made since 1946. Senator Murray's summary, referred to in his letter, was forwarded by me to Leo Linder, esquire, chairman of our national committee on social legislation on May 12, 1947. It is quite evident that our action was based upon this memorandum of Senator Murray and not upon any information supplied by the committee for the nation's health.

Sincerely yours,

ROBERT J. SILBERSTEIN, *Executive Secretary.*

Senator DONNELL. Your organization has a chapter here in the District of Columbia?

Mr. SILBERSTEIN. It does.

Senator DONNELL. It has been pretty active in the last year or so.

Mr. SILBERSTEIN. Not as active as I would wish it.

Senator DONNELL. It has been active?

Mr. SILBERSTEIN. Yes, sir.

Senator DONNELL. Do you remember a meeting held on the 7th of March 1946 in the National Archives Building under the auspices of the National Lawyers Guild?

Mr. SILBERSTEIN. I was discharged from the Army of the United States the 3d of April and continued on terminal leave until about the 3d of May, and I was not familiar with anything going on during the 40 months before that except what I read.

Senator DONNELL. You have no knowledge of who the speakers were at that meeting if such a meeting was held?

Mr. SILBERSTEIN. No, sir.

Senator DONNELL. Mr. Silberstein, you are not a member of the Communist Party, are you?

Mr. SILBERSTEIN. I am not.

Senator DONNELL. Did you sign a certain statement urging the President and Congress to defend the rights of the Communist Party?

Mr. SILBERSTEIN. I did not, sir. I mean, not that I recall. I would be tremendously surprised if I have.

Senator DONNELL. Let us see. Your full name is Robert J. Silberstein, New York City.

Mr. SILBERSTEIN. Right.

Senator DONNELL. Do you know whether there is any other Robert J. Silberstein in New York City?

Mr. SILBERSTEIN. I am quite sure there is not.

Senator DONNELL. I have before me a volume here which is denominated Investigation of Un-American Propaganda Activities in the United States, issued by the United States Government Printing Office in Washington, D. C., in 1944, and at pages 647 to 650 of that publication is a long list of names, at the head of which is this:

> Signers of statement "Defend the Communist Party." Following is complete list of 450 prominent Americans who signed a statement urging the President and Congress to defend the rights of the Communist Party—

and among those names appearing on page 650 is "Robert J. Silberstein, New York City."

Do you know anything about that?

Mr. SILBERSTEIN. I certainly do not. What is the statement?

Senator DONNELL. The statement does not appear here, but it says it is a statement urging the President and Congress to defend the rights of the Communist Party.

Mr. SILBERSTEIN. I will say unequivocally I never signed any such statement. It is absolutely false.

Senator DONNELL. That name is on page 650.

Mr. SILBERSTEIN. I cannot explain it.

Senator MURRAY. Would you state, Mr. Chairman, what the publication is?

Senator DONNELL. It states:

> Investigation of Un-American Propaganda Activities in the United States, Special Committee on Un-American Activities, Seventy-eighth Congress, second session, H. R. 282.

Mr. SILBERSTEIN. I would like for you to read that citation more slowly, Mr. Chairman.

Senator DONNELL. Un-American Propaganda Activities in the United States, Special Committee on Un-American Activities of the House of Representatives, Seventh-eighth Congress, second session, on H. R. 282, to investigate——

Mr. SILBERSTEIN. Would you mind giving me the document number?

Senator DONNELL. Yes; it is Document—I do not see one, but it is marked "Committee print, appendix, part 9," with special reference to——

Mr. SILBERSTEIN. When is this statement supposed to have been made, Senator?

Senator DONNELL. You mean——

Mr. SILBERSTEIN. The statement I am supposed to have signed.

Senator DONNELL. I do not know. I have read all it says, list of signers of statement "Defend the Communist Party." Following is complete list of 450 prominent Americans who signed a statement urging the President and Congress to defend the rights of the Communist Party, and then there is a long list of names, and your name, Robert J. Silberstein, appears on page 650.

Mr. SILBERSTEIN. I may state I am certain I never signed any such statement. Furthermore, I cannot see how it is in any way germane to the issue here. I was good enough to serve in the Army of the United States for 40 months as a private and an officer in the Signal Battalion overseas, which should entitle me to state my views without being subjected to this kind of questioning, which is completely ungermane.

Senator DONNELL. Perhaps the committee may exercise its own judgment as to the germaneness. You are entitled to your own opinion on that too, but I have asked you about that.

Mr. SILBERSTEIN. I have answered your question, but I appeal to your good judgment not to pursue the line of attack which can only serve to distract attention from the real issue we are discussing, that is, the merits of the bill. I am here advocating something that a number of Senators have advocated——

Senator DONNELL. The committee will decide——

Senator MURRAY. I would like to get the witness' answer without him being interrupted by the chairman.

Senator DONNELL. Let him proceed.

Senator MURRAY. I want him to proceed. I want to make my own statement too.

Senator DONNELL. Which do you want first?

Senator MURRAY. I want to make my statement.

Senator DONNELL. You may make yours.

Senator MURRAY. I object to the chairman interrupting the witness when he is in the process of making a statement. I think the chairman of this committee is not treating the witness with the courtesy he is entitled to. He has gone out and risked his life as a member of our armed forces. I think he is entitled to courteous treatment before this committee.

Senator DONNELL. He is receiving it.

Senator MURRAY. I think it is utterly unfair to ask him if he is a Communist, even. I think it is an insult to this man who has offered his life to his country to be brought here and subjected to treatment of this kind, and I want, as one member, to interpose my objection to such tactics.

Senator DONNELL. I want to call attention to the fact Senator Murray asked one witness this morning if he was a Communist.

Senator MURRAY. Yes. You had dwelt on it for an hour. I thought it ought to be brought out. You probably would have brought it out later on, I suppose, because you indicated complete understanding of the situation involved. You had prepared very carefully for it. You had very extensive notes prepared by a staff member here who had devoted a great deal of time to it. The witness came here voluntarily, not at the request of the proponents of this measure. He insisted on coming here. I did not want him. I understood when we proposed the witness could file a statement it would be satisfactory, but some member of the committee here insisted on his appearing. I do not know for what purpose. We did not want him as a witness.

We did not propose him as a witness, but he was brought here and a great deal of time put in on the subject of whether he was connected with the Communist Party or was a Communist, and I thought it was proper to bring out the facts fully and completely.

Senator DONNELL. May I ask the Senator very respectfully whether or not he is indicating whether the acting chairman of this committee expressed an unwillingness to hear Mr. Rymer?

Senator MURRAY. He was not on our list of proposed witnesses. I know that.

Senator DONNELL. I did not know he was coming and had nothing to do with his coming, directly or indirectly.

Senator MURRAY. Things like that occur. I do not know how it happened. He was not my witness. He was not here at my request.

Senator DONNELL. My understanding is that Mr. Rockwell Kent had expected to be here and he came in his place.

Senator MURRAY. We have people from all over the country demanding to be heard here, and we selected a list of witnesses that we desired to present here in support of the measure, and those were the only witnesses we were interested in.

Senator DONNELL. I might state both to Senator Murray and Mr. Silberstein that there is no desire at all to stop Mr. Silberstein from making his statement, even if I interrupted him.

I stated to him two or three times to proceed, and I would be glad to have him proceed. The opportunity is present right now for him to say whatever he wants to and in full.

Mr. SILBERSTEIN. I have forgotten what it was. I do not feel it is important. My whole feeling is this whole line can serve no purpose except to divert attention from the merits of the proposal I am here to discuss.

Senator MURRAY. This committee has a hired staff and has a member of the staff paid by the United States Government sending out propaganda against this measure and who has circulated stories to the effect that we who sponsor this legislation are Communists or fellow travelers or collaborationists. I resent that. I do not think this committee should permit this kind of conduct in the United States Senate. I think it is a disgrace to the Congress to have a proceeding of this kind.

These proceedings ought to be upon an honest and fair basis—open, honest, and fair—and not conducted by professional propagandists.

Mr. SILBERSTEIN. I certainly agree with you.

Senator DONNELL. He is in error in thinking Dr. Shearon, who sits at my right, is a member of the committee staff.

Senator MURRAY. She was fired or discharged at my request.

Senator DONNELL. May I complete my statement. Her connection with this committee terminated on the 30th day of June. She is not connected with the committee and not on a salary.

Senator MURRAY. Then what right has she to be here?

Senator DONNELL. She is here to assist me.

Senator MURRAY. She has no right to be here sending out propaganda from this committee, from the Senate Building, sending out propaganda all over the United States to smear this legislation. I resent it, and I do not think she should be permitted to remain in this committee any longer.

I am going to call a special meeting of the committee at an executive session and find out if this committee is going to continue this kind of course with this legislation. I think it is unfair and unjust to the people of this country to have a situation of this kind and to think it can exist.

Senator DONNELL. Have you finished, Senator?

Senator MURRAY. Yes; I have finished.

Senator DONNELL. May I ask you, Mr. Silberstein, whether you are president of the Lawyers Security League, 38 Park Row, New York City?

Mr. SILBERSTEIN. I was. The Lawyers Security League ceased to exist some time in 1938.

Senator DONNELL. I would like to mention the Lawyers Security League with yourself as president is likewise listed in the fourth section of this Committee Print of Investigation of Un-American Propaganda Activities in the United States. I do not know what the particular purpose of that is, but exhibit No. 70 under the heading of "Miscellaneous Communists and Communist front organizations——"

Mr. SILBERSTEIN. I am very proud to have been a member of that organization and to have been its president, and I would even say it would be a mark of dishonor not to be listed there since I do not know of any organization which has supported measures in the interest of the common people of the United States who is not found to be there. I think it is regrettable that despite the excesses and disgraceful conduct of that committee, the chairman of this committee should utilize it in a course of conduct which would have a tendency to intimidate.

Senator MURRAY. Mr. Chairman, I should like to have a list of the members of that committee.

Senator DONNELL. I will supply that. I should like to read you from the top of page 1067, section 126, of the fourth section of the report, this:

> Miscellaneous Communists and Communist front organizations: In this section of the report will be found numerous exhibits of Communists and Communist front organizations. The personnel of these organizations reveals an extensive interlocking directorate with the other organizations that are discussed in these volumes. In his article on the National Federation for Constitutional Liberties, the Attorney General has called attention to the mass of interlocking directorates

in identifying Communist front organizations. The exhibits reveal a part of the personnel of the following organizations.

After which follows a list of 102 organizations and No. 70 of which is Lawyers Security League, and the exhibit 70 appears at page 1133 of the same book, listing the Lawyers Security League, 38 Park Row, New York City, Robert J. Silberstein, president.

You asked for the names of the Special Committee on Un-American Activities. It is as follows:

Martin Dies, Texas, chairman; Jo Starnes, Alabama; Wirt Courtney, Tennessee; John M. Costello, California; Herman B. Eberharter, Pennsylvania; J. Parnell Thomas, New Jersey; Karl E. Mundt, South Dakota; Fred E. Busby, Illinois; and Robert E. Stripling, secretary and chief investigator; and J. B. Matthews, director of research.

Mr. SILBERSTEIN. Now, Mr. Chairman, you have introduced that statement regarding the Lawyers Security League which makes it proper to grant me a full opportunity to explain what the Lawyers Security League was.

Senator DONNELL. I shall be glad to give you full opportunity to do so.

Mr. SILBERSTEIN. The Lawyers Security League was organized in 1934. At that time in the city of New York there were hundreds, perhaps thousands of lawyers who were unemployed and at a level approximating starvation. Many of them were on relief. Those who secured employment in WPA were obliged to do the work of manual labor, thus losing for themselves the skills which they had gained after very long training in colleges and universities.

The purposes of the Lawyers Security League were to endeavor to do something to assist these people. I was then associated with a firm of distinction and long standing, known as the firm of Gelner, Simon & Asher, of which I became a partner in the year of 1940. Our primary function, almost our total function, was to devise projects for utilization by WPA which would enable lawyers on WPA to do legal work instead of manual work which destroyed their skill.

Through the efforts of this organization, projects which it designed with the help of Government agencies were established in the city of New York, in various Government agencies, in the courts, in the office of the county clerk, in the corporation counsel's office, and the lawyers under WPA were assigned to do the work of a lawyer, to maintain their skill.

At the time I was the president of this organization, it is my best recollection I was not an officer or director of any other organization, nor do I know of any member that I can recall of the board of directors or among the officers who was then connected with any other organization in an official capacity, as a member of the board of directors or as an officer.

The statement which is made by the committee must, therefore, be utterly and completely false, and I want to repeat that I have only the greatest pride for the work which I did in that organization and the work which the organization did.

Senator DONNELL. The statement which you said is false, you mean by the Special Committee on Un-American Activities.

Mr. SILBERSTEIN. The statement with regard to this organization or with interlocking directors?

Senator DONNELL. The committee to which you refer is the Special Committee on Un-American Activities of the House of Representatives?

Mr. SILBERSTEIN. The particular statement which you read into the record.

Senator DONNELL. I am saying the committee. You are talking about the statement——

Mr. SILBERSTEIN. I said nothing about——

Senator DONNELL. I am asking if you meant that committee when you said that.

Mr. SILBERSTEIN. Whatever I said, Senator.

Senator DONNELL. Very well.

Mr. SILBERSTEIN. What I meant to say, the statement which you read into the record from the committee so far as it relates to the Lawyers Society League is absolutely and unquestionably false.

Senator DONNELL. I would like to ask your comment on this statement appearing also in the third section of this investigation of un-American activities, and the issue is a committee print. It states:

> Among the members of the National Citizens Political Action Committee the following were affiliated with Communist-front organization which was known as the Lawyers Committee on American Relations with Spain:
>
> John Gutknecht, Dorsey Kenyon, John Frederick Lewis, Jr., Carey McWilliams, William A. Neilson, Frederick L. Schuman.

and the following which, at the bottom of that page, is exhibit No. 1, and following which is a considerable list of names, including Robert W. Kenny, and on page 963 the name and address of Robert J. Silberstein.

I will ask you to state if you are the Robert J. Silberstein mentioned there?

Mr. SILBERSTEIN. I believe so.

Senator DONNELL. Do you have any comment with respect to the committee's designation of that organization as a Communist-front organization?

Mr. SILBERSTEIN. I have to say from anything that I know about that organization, and I had no very intimate connection with it, the statement is entirely false, insofar as the committee actually was in behalf of republican Spain and against the invasion by Franco with the aid of Germany and Italy, and I certainly applaud whatever it did wholeheartedly and still do, and would then or now do anything in my power to further its aim to help maintain a democratic government or restore a democratic government in Spain.

Senator DONNELL. Have you personally studied the progress of wholesale health insurance in any nation in the world?

Mr. SILBERSTEIN. I have not, sir.

Senator DONNELL. Have you read any books on that subject?

Mr. SILBERSTEIN. I have not, sir.

Senator DONNELL. Have you read any articles on it?

Mr. SILBERSTEIN. I may have seen some, but I do not recall clearly the contents of them.

Senator DONNELL. So you are not undertaking to testify as to the success or failure of wholesale health insurance in any other nation in the world?

Mr. SILBERSTEIN. I am not.

Senator DONNELL. That is all, Mr. Silberstein.

Senator MURRAY. I want to thank you for your appearance here, and I regret very much the treatment you have received.

(The brief submitted by Mr. Silberstein in behalf of the National Lawyers Guild follows:)

STATEMENT OF NATIONAL LAWYERS GUILD ON THE TAFT-SMITH-BALL-DONNELL NATIONAL HEALTH ACT OF 1947 (S. 545) SUBMITTED TO THE HEALTH SUBCOMMITTEE OF SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE AT HEARINGS ON JULY 3, 1947

The National Health Act of 1947 (S. 545, 80th Cong., 1st sess.) is a revision of S. 2143, introduced by Senators Taft, Smith, and Ball in the Seventy-ninth Congress, second session. The proponents, in introducing the earlier bill, have declared that it is "intended entirely to replace" the Wagner-Murray-Dingell proposed national health insurance program.

President Truman, in his message to Congress on May 19, 1947, declared that our country has thus far failed to provide protection against the basic risk of sickness. He declared that the national welfare and security urgently required the immediate adoption by the Congress of a five-point long-range health program, including the following:

1. Adequate public-health services, including an expanded maternal and child-health program.
2. Additional medical research and medical education.
3. More hospitals and more doctors in all areas of the country where they are needed.
4. Insurance against the costs of medical care.
5. Protection against loss of earnings during illness.

President Truman declared that—

"The total health program which I have proposed is crucial to our national welfare. The heart of that program is national health insurance. Until it is a part of our national fabric, we shall be wasting our most precious national resource and shall be perpetuating unnecessary misery and human suffering."

S. 545 does not provide the program proposed by President Truman. It makes no provision whatever for a health-insurance system. Nothing contained within it would give the American people a might to medical, dental, and hospital care.

I. ANALYSIS OF S. 545

S. 545 makes the following proposals:

A. The creation of a single National Health Agency, to which the functions of various existing Federal health bodies would be transferred.

B. Appropriations for medical and dental research.

C. Expansion of the activities of the Public Health Service through Federal grants-in-aid to the States for medical and dental services, to be supplied to families and individuals with low income, and for various health-inspection and dental-health services for school children.

The proposals of S. 545 in each of these matters may be summarized briefly as follows:

A. National Health Agency

S. 545 contains a finding that "health and medical functions are widely scattered through many agencies in the Federal Government, with resultant confusion and duplication of effort" (sec. 2 (a), pp. 1–2). The bill proposes that an independent agency be created in the executive branch of the Government, to be known as the National Health Agency, to be administered by a National Health Administrator, who must be a doctor of medicine "outstanding in the field of medicine"[1] (sec. 101 (c), p. 3). To this National Health Agency there would be transferred the functions, powers, and duties of the present Public Health Service, the Food and Drug Administration, the Children's Bureau in the Department of Labor insofar as it was concerned with the administration of certain provisions of the Social Security Act, the Division of Health Studies in the Bureau of Research and Statistics of the Social Security Board, and other agencies. The new National Health Agency would then be composed of constituent units comparable to the agencies thus transferred. Except for the Surgeon General of the Public Health Service, the heads of all the constituent agencies are to be appointed by the Administrator. The medical and hospital care services would be under the administration of the Office of Medical and Hospital Care Services, headed by a Director who is required to be a doctor of medicine with "at least 5 years of active medical practice." The dental-care services provided for in the bill would be administered by an Office of Dental Care Services, headed by a Director required to be a doctor of dental surgery, with "at least 10 years of active practice" (sec. 104 (c), p. 9).

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[1] In the 1946 bill, the Administrator was required to be a doctor of medicine with experience either in the Public Health Service or in active practice and in medical research, training, or administration (S. 2143, sec. 101 (c), p. 3).

B. Appropriations for medical and dental research

The bill proposes the following provisions to expand the research activities of the Public Health Service:

1. Ten million dollars is authorized to be appropriated to enable the Surgeon General to develop more effective measures for the prevention and control of cancer and to assist the States in establishing and maintaining measures for the prevention and control of this disease (sec. 203, pp. 12–13).

2. A National Institute of Dental Research would be established as a division in the National Institute of Health, and there would be authorized for appropriation for grants-in-aid for dental research training over a 5-year period sums which would start at not more than $75,000 for the first year, and rise to not more than $300,000 for the fourth and fifth years, and for research and scholarships within the National Institute of Dental Research sums not to exceed $175,000 for the first year, and rising to not more than $300,000 for the fourth and fifth years (title IX, pt. A, 40–44).

3. There would be authorized for appropriation not over $2,000,000 for erection and equipment of buildings and other facilities for the use of the National Institute of Dental Research (title IX, pt. B, p. 44).

It should be noted that the proponents of S. 545, in revising their earlier bill, S. 2143, omitted from the present bill the provisions of the earlier bill for appropriations of $4,500,000 for medical research in and operation of the National Health Institute (S. 2143, sec. 203, p. 12), and also omitted the previous provision for a National Institute of Neuropsychiatric Research, with appropriations ranging from $300,000 in the first year to $700,000 in the fourth and fifth years (title IX, pt. B, pp. 37–42), as well as an appropriation of $4,500,000 for buildings and other faculties for use of the National Institute of Neuropsychiatric Research (title IX, pt. C, pp. 42–43).

C. Federal grants-in-aid to States for medical and dental care for the poor

S. 545 proposes to amend the Public Health Service Act by adding title VII, providing for "general medical service for families and individuals with low income" and adding title VIII, providing for "dental health services for school children and families and individuals with low income." The scheme proposed is that of Federal grants-in-aid to the States for medical care services to be administered by the Director of Medical and Hospital Care Services, acting in consultation with a National Medical Care Council, consisting of the Director, as Chairman, and eight members appointed by the Administrator of the National Health Agency, five of the eight members to be "persons outstanding in fields pertaining to medical and hospital care, at least four of whom shall be doctors of medicine" (secs. 711, 715A, pp. 16–17, 24–26). The scheme proposed for the administration of Federal grants-in-aid to the States for dental health services is that these grants shall be administered by the Director of Dental Care Services, who shall act in consultation with a National Dental Health Council, consisting of the Director, as Chairman, and six members appointed by the National Health Administrator, all of whom shall be persons who are outstanding in fields pertaining to dental health, at least four of whom shall be doctors of dental surgery who "have had not less than 10 years of active practice" (secs. 811, 812, 815, pp. 29–39).

1. *Federal grants-in-aid for general medical services for low-income families and individuals (proposed new title VII of Public Health Service Act).*—The bill would authorize appropriation of $200,000,000 annually for 5 years, the funds to be used for making payments to States submitting State plans, approved by the Director of Medical Care Services (sec. 711, pp. 16–17) for State-wide programs "designed and calculated to provide within 5 years" the following: "hospital services, surgical services, and medical services," to be provided "in institutions, in the home, or in physicians' offices," and to be available for "all those families and individuals in the State having insufficient income to pay the whole cost of such

services." In addition, the State-wide programs would have to be "designed and calculated to provide within 5 years periodic physical examinations for all children in elementary or secondary schools in the State" (sec. 712 (a) (4), pp. 17–18). Significantly, the bill provides that no plan may be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated by July 1, 1952, to provide hospital services, surgical services, and medical services, and periodic physical examinations for all those families an individuals in the State having insufficient income to pay the whole cost of such services, and also provides periodic physical examination services for all children in elementary or secondary schools "at a cost within the probable financial resources of the State with Federal aid" (sec. 712 (b), pp. 20–21). The bill provides that the State plan must require "the collection of proper charges of less than the total cost of such services from persons unable to pay in whole, but able to pay in part therefor" (sec. 712 (a) (4), pp. 18–19). A State plan may provide for the furnishing of such services "by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor" (sec. 712 (a) (4), p. 18). The plan must be based upon a "State-wide inventory" of existing medical, surgical, and hospital care and "describe in detail the extension of such services to the end that such services be furnished without discrimination on account of race, creed, or color to all persons unable to pay in full therefor" (sec. 712 (a) (7), p. 20). S. 545 would authorize to be appropriated $3,000,000 for grants-in-aid to the States for making a medical-care survey which would provide an inventory of existing care and facilities (title VII, pt. A, pp. 14–16).

The extent of Federal aid is limited by the following formula: The State's financial participation in the plan must be "at least equal to the amount contributed for similar purposes in the year 1946 and at least equal to the Federal aid" (sec. 712 (a) (5), p. 19). The $200,000,000 Federal fund appropriated annually for the 5-year period is to be distributed between the States on the basis of (*a*) the proportion which the population of such State bears to the population of all States having approved plans and (*b*) the proportion of "taxpaying ability" of the State to the taxpaying ability of all States having approved plans, the percentge of taxpaying ability being the percentage which "bears the same ratio to 50 percent as the per capita of continental United States * * * bears to the per capita income of such State, except that such percentage shall be no more than 66⅔ percent or less than 25 percent" (sec. 713, pp. 21–22).

In administering the program, the Director is required to consult with the National Medical Care Council (sec. 715 (b), p. 24). The National Medical Care Council is given the power to afford any State whose plan has been disapproved by the Director an opportunity for hearing. If the National Medical Care Council determines that the plan complies with the act, the Director is required to approve the plan (sec. 712 (b), pp. 20–21). A State which is dissatisfied with the Director's action may appeal to the United States Circuit Court of Appeals, and final power of review is granted to the Supreme Court of the United States (sec. 714 (b), pp. 22–24).

2. *Federal grants-in-aid for dental health services for school children and families and individuals with low income (proposed new title VIII of Public Health Service Act).*—The bill would appropriate $8,000,000 for the first year, and increasing sums thereafter until reaching $20,000,000 in the fourth or fifth years, to provide for Federal grants-in-aid to States submitting plans approved by the Surgeon General (sec. 811, pp. 29–30).

The scheme for the State plans under this title is substantially the same as that provided in the proposed title VII. The State plan would have to be one "designed and calculated within 5 years to provide for the annual inspection of the teeth of all children in elementary and secondary grades of the public and private schools in the State," and, in addition, "to provide for the care and treatment, including prophylaxis, filling, X-ray, extraction, and related care, other than straightening, of the teeth of those children in the elementary and secondary schools of the State who, and whose family or guardian, have insufficient income to pay for the whole cost of such services" (sec. 812 (a) (4), pp. 31–32). The State plan must require "the collection of proper charges of less than the total cost of services rendered * * * to individuals and families unable to pay in whole or able to pay in part therefor" (sec. 812 (a) (4), pp. 31–32). The State plan may, "at the option of the State," provide "dental care for those families and individuals in the State having insufficient income to pay the cost of such services" (sec. 812 (a) (4), pp. 31–32). The program may also provide for the furnishing of such dental services to such families and individuals by means of payment in the nature of premiums or expense reimbursement to any nonprofit voluntary dental-care fund (sec. 812 (a) (4), p. 32). The State plan must be based upon a "State-wide inventory" of existing dental care and facilities, and the bill would authorize to be appropriated the sum of $1,000,000 for grants-in-aid for the making of a dental survey which could provide such inventory (title VIII, pt. A, pp. 27–29).

This title provides for the same Federal-State financial participation and for the same formulas for determining the proportion of the total appropriation payable to the States as is provided in the title dealing with general medical services (sec. 812 (a) (5), p. 32; sec. 813, pp. 34–35).

In administering this title, the Director of Dental Care Services is required to consult with the National Dental Health Council (sec. 815 (b), p. 37). The National Dental Health Council is given the same final power of reviewing the disapproval of any State plan by the Director, and requiring approval if the Council is satisfied (sec. 812 (b), p. 33), and the title provides for the same right of appeal by any State from the action of the Director to the United States court of appeals and for final review by the Supreme Court of the United States (sec. 814 (b), p. 36).

II. S. 545 MUST BE REJECTED AS A THOROUGHLY UNSATISFACTORY ALTERNATIVE TO A NATIONAL HEALTH INSURANCE PROGRAM

A. The unsoundness of the fundamental conceptions of S. 545 that governmental assurance of medical care should be limited to the poor as a matter of charity rather than to all Americans as a matter of right

A comparison of S. 545 with the program of national health insurance proposed by President Truman and the proposals of national health insurance as would be provided by the Wagner-Murray-Dingell bill indicates that the prime feature of the proposals as President Truman and the Wagner-Murray-Dingell bill is completely absent from S. 545. The prime feature of the Wagner-Murray-Dingell health bill is the creation of a Federal system of medical, dental and hospital care, available virtually to every employed and self-employed person in the United States and to all of his or her dependents. The Wagner-Murray-Dingell bill proposes to vest in virtually every American the fixed legal right to medical, hospital, and dental care, wholly without regard to whether the American has or does not have "insufficient income to pay the whole cost of such services" at the time when he or she needs them, and wholly without regard to whether the American involved has "low income." Thus, the Wagner-Murray-Dingell bill proposes, on insurance principles, to give Americans the right to the care they need when they need it.

S. 545, on the other hand, would provide Federal aid to such States as provided medical and dental care to "families and individuals with low income." The bill would, indeed, provide Federal aid to States which adopted acceptable State programs for health inspection services and dental inspection services, but actual medical and dental care would only be provided by the States to the children and the families having "insufficient income to pay for the whole cost of such services." Thus, S. 545 is, in essence, concerned with paupers and with people who, if not paupers, are unable to pay the full cost of medical and dental care when they need it. The care to be provided under S. 545 is care which is available only upon some demonstration of pauperism or insufficient income. It is not at all available as a matter of right. It is given as a matter of charity in accordance with administrative determination of need. No American under S. 545 has any right to medical care; at the most, if his State qualified for Federal aid, he might have a right to medical relief if he could demonstrate poverty and inability to pay for the full cost of the medical care needed.

Senator Taft has declared that his bill would "probably extend medical care to from 20 to 25 percent of the population." Presumably this is because Senator Taft assumes that only 20 to 25 percent of the population is in a condition of pauperism or at least in the condition of having insufficient resources to meet the cost of medical care. Yet a report of the American Medical Association indicates that, in 1940, families with income under $3,000 a year generally could not meet all the costs of medical care (Factual Data on Medical Economics, revised, 1940, by the bureau of medical economics of the American Medical Association, p. 90). In 1941, 85 percent of the American families had incomes of less than $3,000 a year (Bureau Memorandum No. 57, Federal Security Agency, Social Security Board, Bureau of Research and Statistics, entitled "Need for Medical Care Insurance," published April 1944, p. 11). Fifty percent had less than $1,950. Even in 1944, 60 percent of the American families had incomes under $3,000.

S. 545 thus ignores the fact that a substantial majority of the American people—and not a mere 20 to 25 percent—cannot meet the costs of adequate medical, dental, and hospital care. If we start with this as the problem with which Congress should be concerned, then the next question is whether Congress should attempt to meet the need for medical care of the American people on a national social insurance basis, designed to give virtually all Americans the vested legal right to medical care, or whether medical care should only be provided on the basis of charity to the most pauperized elements of the population, and then only on a State-by-State basis and subject to the willingness and ability of the particular States to adopt a plan acceptable to a Federal Agency.

On principle, it is clear that the Nation as a whole is vitally concerned that all Americans should receive medical care when they need it. In the fields of old-age insurance and unemployment insurance, our country has advanced from the notions of Elizabethan poorhouse charity to a conception of creating a system of vested rights to insurance benefits during periods of unemployment and in old age. The bill still clings to the outmoded approach of the Elizabethan poor laws. It is based upon a conception which must be emphatically rejected.

B. There is no assurance whatever that any medical, dental, or health care will be provided to anyone under the provisions of S. 545

S. 545 appropriates money which is to be given to the States, provided the States submit State plans. There is no compulsion upon any State to submit a plan. A State may decline to submit a State plan, or it may submit a plan which is not approved. In either event, the Americans resident in such State would be wholly without any benefit under S. 545.

Nor is there any assurance that even the limited proposals of S. 545 will be put into effect immediately. For S. 545 contemplates State plans "designed and calculated by the end of [a] 5-year period" to provide medical care "at a cost within the probable financial resources of the State with Federal aid" (sec. 712 (b), p. 21.)

The proposal for Federal aid is sharply limited. The States are required to put up an amount equal to the amount of Federal aid.

Thus, S. 545 really provides no assurance that its proposals with respect to health care will be made available to anyone.

C. The limitations upon the health care to be provided under S. 545

The State programs contemplated by S. 545 must be "designed and calculated to provide within 5 years" services for families and individuals in the State having insufficient income to pay the whole cost of such services. It is up to the State to determine what constitutes "insufficient income." The State plan must provide for the collection of proper charges of less than the total cost of the services from persons unable to pay in whole but able to pay in part therefor. Thus, the State would have to set up administrative machinery for investigation for determining precisely what the income and resources of the individual are, and machinery for making sure that the services are paid for to the extent that the individual can pay for them.

Insofar as dental care for children is concerned, this is to be provided only where the children's families have "insufficient income to pay for the whole cost of such services," and where the families are able to pay in part the plan requires the "collection of proper charges," to the extent of ability to pay (sec. 812 (4), p. 31). This, therefore, is a proposal for dividing our school children on the basis of the economic status of their parents, which is contrary to the democratic concept of universally free education and equal treatment.

So far as medical care is concerned, the State plan need only provide for services at an institution (sec. 712 (a) (4), p. 18). A State plan may, at the State's option, provide for medical care at the patient's home or physician's office, but this is not required. What is here proposed is a system of "relief" medicine based upon a double standard of medical care; one for those who have sufficient income to pay for the medical care they receive, and the other for those who are so unfortunate to have "insufficient income to pay the whole cost" of the services they require. S. 545 formulates no standards for what it describes as "insufficient income to pay the whole cost" of the medical services involved.

Each State would decide for itself, or it would leave it to its counties, towns, or cities to decide, what constitutes "insufficient income." Each State would decide for itself what would constitute "proper charges" to be imposed upon persons "unable to pay in whole or able to pay in part" for medical services received. Each State would decide for itself what kind of medical care and what kind of dental care should be provided for.

S. 545 does not spell out administrative policies with respect to the nature of the care and services to be provided, nor is it concerned with methods of administration, including the methods of making payments to practitioners. The detailed provisions of the Wagner-Murray-Dingell health bill (S. 1606, sec. 205, pp. 45–51) are wholly absent from S. 545. The sponsors of S. 545 are presumably satisfied to leave all of these matters to the States, and presumably they are satisfied that the medical professional people will be protected because they have taken great pains to make sure that medical professional people dominate the administration. Interestingly enough, however, S. 545 does permit a State plan to "include annual payments to physicians practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician" (sec. 712 (4), p. 19). Thus, "socialized medicine" proposals are satisfactory to the sponsors of S. 545 so long as they are limited to the administration of medical care for paupers, or for those unable to pay the full cost of medical care.

Thus, the coverage of S. 545 is limited to a fraction of the population—those who are of "low income," whatever that may mean. The benefits provided by the bill are left to the States to determine. The bill refers to "hospital services, surgical services, and medical services," but it is up to the States to determine what these services shall consist of and where and how they shall be available. The "periodic physical examinations" for school children are not related to any effort to correct conditions found. There is no provision whatever in the bill for laboratory services, for drugs, for X-ray, for physiotherapy, or home-nursing services. There are no standards for the hospital, surgical, medical, or dental services to be provided.

The bill does nothing to make available physicians or other personnel in areas needing them. There is no provision in S. 545 to indicate the method of payment for professional services. There are neither maxima nor minima provided, nor are any formulas or standards indicated.

From the standpoint of administration, S. 545 is designed to place the control of administration in the hands of practicing physicians. Its provisions would debar Public Health Service administrators who are not medical or dental practitioners. Whereas, in their 1946 proposal, the proponents of S. 545 were content to leave administration primarily in the hands of the Surgeon General, the present bill indicates an effort to divorce the Pacific Health Service from any participation in the administration of a program of medical and dental care, and sharply to differentiate and separate the administration of preventive from therapeutic services.

D. The inadequacy of S. 545 from the standpoint of its financial provisions

S. 545 would spend $200,000,000 annually on a program of medical services. If the States were to spend $1 for every Federal $1 granted, this would mean an expenditure of $400,000,000 annually on the program provided by this bill. In the last few years, medical-care expenditures by the American people approximated $5,000,000,000 annually. This bill thus proposes an expenditure of 8 percent of current expenditures for medical care.

The low-income States will, under the bill, be entitled to proportionately larger sums of money, but they are required to match the Federal grant in the same way that high-income States match it.

The appropriations for dental care are deemed by the Physician's Forum to be "so trivial, relative to the need, as to be hardly a gesture in recognition of the problem. Starting out with an annual amount of grants of $8,000,000, it builds up to $20,000,000—sums which, when matched, would provide much less than 10 percent of present expenditures for dental care. Present expenditures are, of course, far smaller than required to meet our dental needs, so that the surface of the total problem will hardly be scratched when the maximum appropriation is reached" (Physician's Forum Bulletin, March–April 1947, p. 13).

In comparison with the limited and restricted proposals of S. 545, the Wagner-Murray-Dingell bill proposes not only substantially complete coverage, but comprehensive services emphasizing preventive medicine, diagnosis, and early treatment of disease, with elaborate provision for protecting professional people rendering services.

PROPOSALS TO FINANCE RESEARCH UNDER S. 545

There can be no objection to the commendable proposal for financing further research in the fields of dental science and cancer. The proposals for appropriations to finance a Dental Research Institute and cancer research are all warmly approved. Unfortunately, these commendable proposals are buried in and are tied to thoroughly unsatisfactory proposals for expanding the activities of the Public Health Service. They have, unfortunately, become part of a program which is not a satisfactory alternative to the Wagner-Murray-Dingell national health bill.

CONCLUSION

S. 545 must be rejected. It does not meet the problem of medical care of the people of the United States. Indeed, it ignores the need for medical care on the part of the majority of the American people.

S. 545 is solely concerned with paupers and with those unable to pay the full costs of medical and dental care. While unquestionably those who are impoverished should be provided with medical care, this care should be provided as part of a system of medical care available to all Americans. The restriction of governmental aid for medical care to the impoverished means that such medical care is given only upon a demonstration of poverty. The overwhelming majority of Americans who are self-supporting are still unable to pay the unexpected costs of catastrophic or prolonged illness, and it is not in the national interest to subject them to the degradation of a means test and to make them demonstrate that they are paupers, or are financially unable to meet the costs of illness before they can receive the medical care which they need. Furthermore, the restriction of governmental aid for medical care to Federal grants to the States means that we must rely upon State-by-State action, and that unless each State acts, its citizens receive no benefit. The disease and ill-health of Americans everywhere is a matter of national concern, and it is thus in the national interest that a national system should assure Americans everywhere the medical care which they need, when and where they need it.

The Wagner-Murray-Dingell National Health Act means the national need by creating a national system administered locally. It provides the medical care which is needed without inquiry as to the means of the recipient and upon the same basis of right as is applicable to unemployment insurance benefits and old-age insurance benefits. The Wagner-Murray-Dingell bill, accordingly, should be enacted and S. 545 should be rejected.

Dated May 24, 1947.

Statement prepared by—

NATIONAL COMMITTEE ON SOCIAL LEGISLATION,
NATIONAL LAWYERS GUILD,
LEO J. LINDER, *Chairman.*
MORRIS A. WAINGER, *Secretary.*

Report prepared by Leo J. Linder.

NOTE.—The report of the National Committee on Social Legislation, opposing S. 545, and urging its rejection, was approved by the national executive committee of the National Lawyers Guild at its meeting on May 24, 1947.

Senator DONNELL. Is Mr. Keenan here? [No response.]

Is Mr. Foreman here?

Mr. RODGERS. Mr. Foreman has filed a statement.

Senator DONNELL. We would prefer to have him here so we will not receive the statement at this time.

Now, I would like to put in the record, offer for the record, a document, being a report known as the first intermediate report submitted to the Attorney General of the United States on June 30, 1947, by Mr. Harness, chairman of the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, House of Representatives, being entitled "Investigation of Federal Officials' Participation in Formation and Operation of Health Workshops in the West and Northwest, Designed To Implement Pressure Groups in Favor of What Certain Witnesses and Authors of Propaganda Refer to as Socialized Medicine," together with a copy of a letter addressed by Mr. Harness to the Honorable Thomas E. Clark, Attorney General, which letter is dated June 30, 1947, and refers to said report.

(The report and letter referred to appear in the proceedings of July 9.)

Senator DONNELL. The committee will then be in recess until next Wednesday morning at 9 : 30 to convene again at this same location.

(Whereupon, at 3 : 25 p. m., the subcommittee adjourned until 9 : 30 a. m., Wednesday, July 9, 1947.)

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